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September 16, 2004

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FROM: J. Tyler McCauley *Maria Oms for*
Auditor-Controller

SUBJECT: **DEPARTMENT OF HEALTH SERVICES HIV/AIDS RESIDENTIAL CARE
AND SUBSTANCE ABUSE TREATMENT SERVICES RATE STUDY**

The Department of Health Services' Office of AIDS Programs and Policy (OAPP) contracts for residential and substance abuse treatment services for persons living with HIV/AIDS. OAPP was concerned that, because the current contract reimbursement rates have been in effect since 1997, they may not reflect the current cost of providing the services based on changes in client needs and treatment methodologies.

At the request of OAPP, we engaged Mercer Government Human Services Consulting under our Master Agreement to perform an independent review of the reimbursement rates and develop any related recommendations to improve the contracting process.

Attached is a copy of Mercer's report. OAPP is currently soliciting bids for residential and substance abuse treatment services. OAPP will use the reimbursement rates and recommendations contained in Mercer's report as part of the solicitation and contracting process.

Please call if you have any questions, or your staff may call Jim Schneiderman at (626) 293-1103.

JTM:JS
Attachments

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"To Enrich Lives Through Effective and Caring Service"



MERCER

Government Human Services Consulting



**COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health**

Office of AIDS Programs and Policy

**HIV/AIDS Residential Care and Substance
Abuse Treatment Services: A Rate Study**

September 2004

Final Report



Marsh & McLennan Companies



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Executive Summary

The Los Angeles County Office of AIDS Programs and Policy (OAPP) directs the overall response to the HIV/AIDS epidemic in Los Angeles County. As part of its mandate, OAPP contracts with numerous service providers in various categories to provide high quality and cost-effective care services to HIV-positive residents of the Los Angeles County. Two such services are HIV/AIDS residential care and substance abuse treatment services. In recognition of the improved treatment modalities for people living with HIV/AIDS, and associated changes in client needs, OAPP sought the services of a consulting firm to perform an independent review of the current provider reimbursement rates and to prepare recommendations for fee-for-service (FFS) reimbursement rates for multiple service categories listed below.

Residential Care	Substance Abuse Treatment
<ul style="list-style-type: none">▪ Group Home (GH)▪ Adult Residential Facility (ARF)▪ Residential Care Facilities for the Chronically Ill (RCFCI)▪ Congregate Living Health Facility (CLHF)▪ Transitional Housing (Trans. Housing)▪ Emergency Housing (Emerg. Housing)	<ul style="list-style-type: none">▪ Outpatient Day Treatment (Day Tx)▪ Outpatient Methadone (Methadone)▪ Residential Rehabilitation (Res. Rehab)▪ Residential Detoxification (Detox)▪ Substance Abuse Transitional Housing (Trans. Housing)

Other objectives of this review included the review of standards of care prescribed under regulations; review of the continuum of care, analysis of the costs of providing services based on accepted standards of care; identification of adjustment cost factors, methodologies for future rate changes, guidelines for client fee collection; identification of services reimbursed by third-party payers; and documentation of barriers to rate implementation. Based on a competitive bid for Work Order Request No. 6-29 issued by the Department of the Auditor-Controller of the County of Los Angeles, Mercer Government Human Services Consulting (Mercer) was engaged to complete this study and meet the aforementioned OAPP objectives.

Direct Care Staff-Driven Rate Architecture

Mercer's Direct Service Staff Rate Architecture, tailored to the needs and objectives of OAPP, has been utilized to complete this study and arrive at actuarially-sound rates that support clinically-appropriate services. The four standard cost components included in this architecture are: direct service staff wage, employment-related expenditures, program-related expenditures, and general and administrative expenditures.

The rate architecture is a unique approach to reimbursement for health services in that it emphasizes "hands on" staff resources provided to the people receiving services and varies according to the quality and quantity of that staff time. Three key principles serve as the foundation for this system:

1. *The most prominent and important variable in the determination of quality and the successful adherence to care standards is the Direct Service Staff profile.*
2. *All other cost components, which are equally necessary, although less directly variable in response to differences in standards of care, can be expressed in relationship to Direct Service Staff costs.*
3. *If all the compensation components are studied and their relationships to Direct Service Staff cost profiles can be determined, a standardized rate system can be produced by establishing profiles, in accordance with standards of care, and then building the total compensation (rate) according to the relationships of the other components to the service staff costs.*

Study Methodology

The methodology adopted for this study has been specifically designed and successfully tested in numerous environments and jurisdictions to ensure reliability and soundness of the rates and a strong linkage to appropriate standards of service. In brief, the methodology consists of the following steps:

- review of study methodology with providers,
- collection and analysis of available information including clinical standards, best practices, California and national regulations and codes, and provider cost reports,
- development of service descriptions and performance measures for each service category,
- completion of provider surveys and interviews to collect additional information and to understand existing barriers to service delivery,
- establishment of appropriate type and quantity of direct service staffing levels specific to the service descriptions and the creation of a Direct Service Staff Wage File based on Bureau of Labor Statistics for the County of Los Angeles,
- calculation of cost components to be incorporated into the rate architecture such as employment-related expense and general and administrative expense percentages,
- synthesis of draft rates based on the combination of the various cost components,
- completion of budget impact and provider impact analysis, and
- finalization of rates.

Study Outcomes

The outcomes and findings that emerged based on this study are numerous and are documented in great detail in the report. A few highlights are listed below:

- Comprehensive service descriptions were developed for each service category included in this study, based on the review of standards, best practices, regulations, and current contracts.
- For each service category, performance indicators were identified and clearly defined.
- Provider interviews revealed that, in general, staffing patterns in provider facilities were consistent with service descriptions.

- Only two of 12 residential care providers were found to be billing Medi-Cal. With the majority of funding for health and support services in California coming from Medi-Cal, participation in this program is critical to maximize funds available for service delivery.
- The lack of sophisticated automated data collection systems force many providers to collect service data manually, usually from the client records, which makes it difficult to track outcomes and adherence to standards of care.
- Various third-party payer sources were identified and potential strategies for ensuring appropriate third-party recoveries, given existing constraints, were presented.
- Certain barriers, both to service delivery and the financing of residential care and substance abuse services in the County of Los Angeles, were identified. These barriers include tracking of third-party reimbursement, duplication of funding in some service categories, availability of alternative funding sources for some categories, regulations that may not adequately reflect the changing profile of HIV/AIDS, staff training related to changing service needs, and the implementation of the proposed rates.
- Rates were prepared for each service category based on the evaluation of standards and through the analysis of provider cost reports. The impact of these rates on OAPP's budget, as well as individual providers, was completed. The rates developed in accordance with the study ("rate architecture") methodology are presented in the summary table below:

RESIDENTIAL CARE SERVICES						
	ARF	RCFCI	GH	CLHF + Hospice	Emerg. Housing	Trans. Housing
Current Rate Range	\$98.00 – \$125.00	\$113.00 – \$135.00	\$124.52	\$425.00	\$35.00	\$25.00 – \$44.00
Rate Developed for Study	\$129.34	\$147.59	\$130.38	\$414.26	\$42.80	\$28.32

Note: Additional considerations, such as Medi-Cal coverage and availability of alternate funds need to be evaluated to understand the policy implications of the rates for GH and CLHF + Hospice. These considerations are discussed in detail later in this report.

SUBSTANCE ABUSE TREATMENT SERVICES							
	Day Tx	Detox	Methadone	Res. Rehab - Low	Res. Rehab - Medium	Res. Rehab - High	Trans. Housing
Current Rate Range	\$35.00	\$225.00	\$51.12	\$69.35 – \$112.00			\$18.00 – 24.20
Rate Developed for Study	\$43.76	\$239.21	\$50.32	\$58.11	\$82.18	\$112.27	\$ 40.27

Note: Additional considerations, such as Medi-Cal coverage and availability of alternate funds (especially Substance Abuse Prevention and Treatment Block Grant Funds) need to be evaluated to understand the policy implications of the rates for methadone. These considerations are discussed in detail later in this report.

- In addition to the proposed rates, adjustment factors based on size and capacity of providers have been created. Mechanisms to address valid and appropriate client absences through the rate system have also been presented in the report.

Recommendations

The report provides a number of recommendations intended to assist OAPP and key stakeholders in addressing the barriers to service delivery and to ensure successful implementation of the new rate architecture. The recommendations have been structured in various categories based on the barriers they are intended to address or mitigate. In the final chapter of the report, key recommendations relating to the procurement of services based on the new rate architecture are summarized according to the optimal timeframe for implementation. For instance, the development of the model contract will be a critical component of implementation and should address the following:

- incorporation of specific opportunities for flexibility in contract language to make mid-contract changes to address any unintended consequences,
- specification of mechanisms for invoicing and billing as services are rendered,
- establishment of requirements for collection of performance measures, staff turnover, and other data, and
- establishment of requirements for encumbrance and reporting in compliance with the Health Resources and Services Administration (HRSA) mandates.

Recommendations are offered on the training that will be needed for both OAPP and provider staff on varying aspects of the program as a result of the new FFS rate schedule. Through the collaboration of the County of Los Angeles and its HIV/AIDS providers, a planned and coordinated implementation strategy, and appropriate training for all those involved, OAPP will be able to successfully implement this rate architecture and thereby ensure a more structured and equitable reimbursement methodology for residential care and substance abuse treatment services.

Policy decisions will need to be made during the request for proposal (RFP) development phase. These include a decision on payment policy for bed-hold days for residential services, a decision on third-party liability, a decision regarding the use of an outside vendor to assist with third-party payment, and decisions on services to be included in the procurement of the future continuum of substance abuse and residential care services.

With regard to these specific policy decisions, Mercer recommends the following:

- **Bed-hold:** OAPP should consider allowance for “bed-holds” when a client is absent from a residential program for medical or therapeutic reasons.
- **Third-Party Liability:** OAPP should expect that providers actively seek and identify third party coverage for services rendered.

- **Third-Party Payment Vendor:** OAPP should consider the use of a Third-Party Administrator to confirm client eligibility and appropriate billing prior to reimbursement.
- **Procurement of Services:** OAPP should consider elimination of services from its funded continuum of care because these services are adequately funded by other payer sources. Most notably, substance abuse methadone treatment services are a high priority Substance Abuse Prevention and Treatment Block Grant funded service as well as a Drug Medi-Cal reimbursable service. Funding for children's services, including group homes, is a mandate for the Department of Children and Family Services. Services provided in Congregate Living Health Facilities are Medi-Cal reimbursable services. In addition, the clinical intensity of this service identifies it as "a residential home... that provides inpatient care..." (California Health and Safety Code, Section 1250-1263). The Ryan White CARE Act prohibits use of CARE Act funds for inpatient services.

A summary of the continuum of care OAPP should consider in future procurement is contrasted with the rates developed in accordance with the study ("rate architecture") methodology for existing services in the following table:

RESIDENTIAL CARE SERVICES							
	ARF	RCFCI	GH	CLHF + Hospice	Res. Hospice	Emerg. Housing	Trans. Housing
Current Rate Range	\$98.00 – \$125.00	\$113.00 – \$135.00	\$124.52	\$425.00	None	\$35.00	\$25.00 – \$44.00
Rate Developed for Study	\$129.34	\$147.59	\$130.38	\$414.26	None	\$42.80	\$28.32
Proposed Reimbursement Rate	\$129.34	\$147.59	None	None	\$140.46*	\$42.80	\$28.32

*Medi-Cal Reimbursement Rate

SUBSTANCE ABUSE TREATMENT SERVICES							
	Day Tx	Detox	Methadone	Res. Rehab - Low	Res. Rehab - Medium	Res. Rehab - High	Trans. Housing
Current Rate Range	\$35.00	\$225.00	\$51.12		\$69.35 – \$112.00		\$18.00 – 24.20
Rate Developed for Study	\$43.76	\$239.21	\$50.32	\$58.11	\$82.18	\$112.27	\$ 40.27
Proposed Reimbursement Rate	\$43.76	\$239.21	None	\$58.11	\$82.18	\$112.27	\$40.27

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BACKGROUND

On March 14, 2003, the Department of the Auditor-Controller of the County of Los Angeles issued Work Order Request No. 6-29 on behalf of the Department of Health Services (DHS)/OAPP. The Work Order Request sought the services of a consulting firm to perform an independent review of the HIV/AIDS residential care and substance abuse treatment service provider reimbursement rates.

The current residential care and substance abuse treatment reimbursement rates have been in effect since 1997. In the last few years, improved treatment modalities for people living with HIV/AIDS, dramatic increases in life expectancy, and associated increases in the incidence of mental illness and other comorbidities, have resulted in significant changes in client needs. This Work Order Request was developed in recognition of these changing needs and the potential impact on reimbursement rates for HIV/AIDS service providers.

The current OAPP rates to providers have been in effect since 1997.

The Work Order Request specified that the project must include a comprehensive study to determine reimbursement rates for providing HIV/AIDS residential care and substance abuse treatment services, at specific standards of care, for people living with HIV/AIDS. The contractor selected to perform this study would be required to complete the following specific activities:

- review standards of care prescribed under Federal, State, and County laws or regulations;
- conduct an in-depth analysis of the costs of providing services based on the accepted standards of care;
- prepare recommendations for continuum of residential care and substance abuse treatment services;
- prepare recommendations for FFS reimbursement rates for each recommended service category;
- identify adjustment cost factors with criteria for providers whose cost reasonably exceeds or is below the average cost, and apply those factors;
- determine an appropriate methodology for future changes to contracted rates;
- identify services that are commonly reimbursed by third-party payers and prepare a report of these services;
- identify barriers, including financial disincentives; and
- establish guidelines for collection of client fees.

A Special Rate Study would develop standards of care and prepare a FFS reimbursement rate schedule linked to these standards.

Service categories for which standards of care would be reviewed and FFS rates would be prepared included:

SUMMARY OF SELECT PROVIDER TYPES FOR RATE ANALYSIS	
Residential Care	Substance Abuse Treatment
<ul style="list-style-type: none">▪ Group Home (GH)▪ Adult Residential Facility (ARF)▪ Residential Care Facilities for the Chronically Ill (RCFCI)▪ Congregate Living Health Facility (CLHF)▪ Transitional Housing (Trans. Housing)▪ Emergency Housing (Emerg. Housing)	<ul style="list-style-type: none">▪ Outpatient Day Treatment (Day Tx)▪ Outpatient Methadone (Methadone)▪ Residential Rehabilitation (Res. Rehab)▪ Residential Detoxification (Detox)▪ Substance Abuse Transitional Housing (Trans. Housing)

Note: The initial work order included an additional service, Methadone Detoxification. Mercer developed a preliminary service description for this category. Based upon the subsequent determination that sufficient funding for this category is available through other funding sources, a service description and rate were not required.

Based on a competitive bid process, the Department of the Auditor-Controller selected Mercer to complete the Residential Care and Substance Abuse Treatment Services Special Rate Study which began in June 2003, and was completed in January 2004.

Mercer's Direct Service Staff Rate System was originally developed as a standardized rate schedule that reflects the needs of the individuals who use services. The rate architecture has a unique approach to rate construction: it emphasizes "hands on" staff resources provided to the people receiving services and varies according to the quality and quantity of that staff time. Three key principles serve as the foundation for this system:

A Direct Service Staff Rate System reflects the needs of clients and is founded upon three key principles.

- 1. The most prominent and important variable in the determination of quality and the successful adherence to care standards is the Direct Service Staff profile.*
- 2. All other cost components, which are equally necessary, although less directly variable in response to differences in standards of care, can be expressed in relationship to Direct Service Staff costs.*
- 3. If all the compensation components are studied and their relationships to Direct Service Staff cost profiles can be determined, a standardized rate system can be produced by establishing profiles, in accordance with standards of care, and then building the total compensation (rate) according to the relationships of the other components to the service staff costs.*

While the Direct Service Staff profile is critical to this rate system, it is not the only cost component necessary to create rates. Rather, the Direct Service Staff profile is the most prominent in supporting the standards of quality care. The clear identification of standards of care for the selected service categories was an integral part of this study, since the goal of the

County of Los Angeles, as well as Mercer, was to develop rates that adequately support the provision of quality services, as defined by current regulations and quality care practices.

This report not only provides rates for the various service categories included within this study, but also summarizes the methodology, findings, barriers to the implementation of the proposed rate system, and recommendations to address these barriers. The key sections of the report are outlined below:

- **Section 2: Service Description Development**
 - Methodology
 - Findings and Results
- **Section 3: Rate Development**
 - Cost Components
 - Methodology
 - Adjustment Factors
 - Future Rate Change Process
 - Findings and Results
- **Section 4: Budget Impact Analysis**
 - Methodology
 - Findings and Results
- **Section 5: Third-Party Payer Reimbursement**
 - Methodology
 - Findings and Results
- **Section 6: Barriers/Disincentives and Recommendations**
- **Section 7: Next Steps**

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SERVICE DESCRIPTION DEVELOPMENT

Methodology

Mercer's methodology for the development of actuarially-sound rates that support clinically-appropriate residential care and substance abuse treatment services for people living with HIV/AIDS is based on the documentation of clear and accurate standards of care for each residential care and substance abuse treatment service category under study. The development of standard service descriptions was the first phase of the study. To successfully complete this phase, Mercer adopted the following approach:

Step 1: Exploratory Meetings with OAPP

Mercer first met with OAPP through face-to-face meetings and telephonic discussions to better understand the current standards of care in existing contracts with selected providers, as well as to understand OAPP's program requirements for the provision of quality services.

Step 2: Literature and Information Review

Following these initial discussions, Mercer performed an in-depth review of information and literature from multiple sources on standards and protocols of care for residential care and substance abuse treatment services. These sources¹ include:

An in-depth review of regulations, OAPP contracts, clinical standards and practice guidelines formed the basis for the development of service descriptions.

- OAPP Documents:
 - Presentation Materials Community Advisory Group Orientation, County of Los Angeles, DHS, OAPP, May 27, 2003; and
 - County contracts with providers,
- California Code of Regulations, notably Title 9 and Title 22,
- Mayor's AIDS Leadership Council, HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches, December 2003,
- Other State Resources:
 - Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999; and

¹ This list is not an exhaustive list of all resources but provides examples of resources reviewed and used. Please see service descriptions in Attachment D for footnoted references.

- Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, and
- National Resources:
 - HRSA printed materials on HIV/AIDS services and supports;
 - Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995;
 - The Assisted Living Workgroup, A Report to the U.S. Senate Special Committee on Aging, April 2003;
 - 2003-2005 Accreditation Manual for Assisted Living, Joint Accreditation, 2002;
 - Guiding Principles for Programs Serving HIV-Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003; and
 - Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White CARE Act Housing Policy, U.S. Department of Health and Human Services HRSA, HIV/AIDS Bureau, with John Snow, Inc., and AIDS Housing of Washington under Contract #240-96-0037.

In addition to the above-mentioned resources, Mercer also contacted and obtained information from other key California State and County Organizations. The organizations contacted and a brief summary of the information obtained is summarized in the following table.

Organization	Contact Person(s)	Information Obtained
Community Care Licensing	Jeanine Bates	Licensing issues pertaining to use of certified nursing assistants (CNAs), Hospice, and CLHFs. Clarification provided that CNAs are not required for residential facilities; documentation of training as a CNA or home health aid or equivalent experience is required for RCFCIs; clarification that regulations pertaining to the use of Hospice service by adults in licensed residential facilities have not yet been released. Referral to DHS for information on Hospice and CLHFs.
HRSA	Helen Harpold	Information on HRSA reconciliation and reporting requirements, General and Administrative Expense allocations, guidelines for rate schedule implementation, and collection of client fees.
California Alcohol and Drug Programs	David Feinberg	Mercer staff had facilitated focus group discussions of substance abuse residential licensure revisions in the late Spring of 2003. These draft regulations were used in the development of standards for substance abuse services.
California DHS	Eileen Harvey and Betty Keller (Medi-Cal reimbursement) Suzette Leveret Clark (facility)	Medi-Cal coverage and reimbursement of services for individuals with HIV/AIDS including Hospice; discussion of Medi-Cal rules pertaining to HIV/AIDS. Licensure of CLHFs; hospice requirements; citations for appropriate regulations.

Organization	Contact Person(s) licensure) Diane Peters (DHS Medi-Cal policy)	Information Obtained
LA County Alcohol and Drug Program Administration (ADPA)	Patrick Ogawa	E-mail communication regarding current ADPA rates for OAPP-funded substance abuse providers.
Residential AIDS Licensed Facilities Coordinator, DHS	Sharon Garcia	Information on Residential AIDS Licensed Facilities (RALF) funding for RCFCI regarding state formula funding for services.
Kaiser Foundation	Jennifer Kates	Medicaid resources and information on eligibility, benefits, and HIV/AIDS federal policy.

Step 3: Development of Service Descriptions

After reviewing and analyzing these materials, Mercer developed draft standards of care (i.e., service descriptions) in each of the categories of services selected for this study. Mercer's primary goal in preparing these documents was to ensure that the rates developed for these service categories were reflective of the most appropriate standards of care and were adequately designed to compensate providers for high quality services.

Step 4: Identification of Performance indicators

Recognizing the importance of clearly-defined performance indicators to measure provider compliance with the established standards, Mercer worked with OAPP to identify potential indicators, both process and outcome-related, and these were included as part of each service description.

Step 5: Provider Interviews

To evaluate current provider practices as compared to the required standards, Mercer performed a series of provider interviews as one of the final steps in this phase of the study. Mercer also used these interviews to explore any regulatory or financing barriers to the provision of services and identified unique provider concerns related to the delivery of quality care.

Findings and Results

Through the first phase of the study, Mercer accomplished a number of key study objectives and uncovered several findings that are outlined below.

Creation of Standards of Care

One of the first deliverables for this study was the creation of service descriptions in each of the selected categories of services. In the County of Los Angeles, the Commission on HIV/AIDS Health Services adopts standards of care established for HIV/AIDS providers. For this reason and based on the input of the OAPP and the Department of the Auditor-Controller, Mercer has appropriately re-titled these standards as "service descriptions" until the Commission on HIV/AIDS Health Services reviews and adopts the standards.

Mercer's primary goal in preparing these documents was to ensure that the rates developed for these service categories were reflective of the most appropriate standards of care and were adequately designed to compensate providers for high quality services. Recognizing the wide variation in care practices, Mercer heavily depended upon established California licensure requirements and regulations to define the required standards and augmented these with current care practice standards in the respective service categories, as documented in the literature.

Each service description included the following sections:

- Licensure Category,
- Definitions and Descriptions,
- Impact of HIV/AIDS,
- Program Requirements,
- Process and Outcome Indicators,
- Required Staffing,
- Length of Stay,
- Services, and
- Medi-Cal Coverage.

Service descriptions are included as **Attachment D** of this report.

Development of Key Performance Indicators

Mercer worked with OAPP to identify performance indicators for each service category and subsequently held conversations with OAPP staff to discuss these indicators. OAPP is currently working to identify a core set of indicators that will be part of mandatory reporting requirements from residential care and substance abuse treatment providers. In selecting and refining these indicators, special consideration is being paid to ensuring consistency with the language provided by HRSA in its Outcomes Technical Assistance (TA) Guide. Additionally, Mercer recommends that the effort to revise and report indicators be tied to the next cycle of RFP procurements to maximize the likelihood of success in obtaining valid indicator results from OAPP providers. Mercer's evaluation of both the indicators that OAPP has chosen to include within the service descriptions, as well as additional indicators of relevance, is included as **Attachment A** of the report. Mercer's evaluation is based on the relative ease of data capture and measurement for each indicator and the strength of the relationship between the indicator and quality of service delivery.

Provider Interviews

Mercer interviewed all of the 12 residential care providers and seven of the nine substance abuse treatment providers offering HIV/AIDS services in the County of Los Angeles. Two substance abuse providers were unavailable for interviews during the study period. It must be noted that the information obtained through the interviews is self-reported and has not been subjected to in-depth verification and validation processes. Wherever appropriate, information has been corroborated through discussions with OAPP. A listing of the providers interviewed is included as **Attachment B**. The interview guide is included as **Attachment C**.

In general, the providers reported staffing patterns and activities that are consistent with the service descriptions. When there were differences, Mercer reviewed the service descriptions and, in consultation with OAPP and the Department of the Auditor-Controller, made some minor modifications. The table below outlines responses to key interview questions.

SUMMARY OF SELECT PROVIDER INTERVIEW QUESTIONS		
Topic	Residential Care	Substance Abuse Treatment
Number of Providers Currently Contracted	12	9
Number of Providers Interviewed	12	7
Number of Providers Certified to Bill Medi-Cal	3	4
Number of Providers Billing Medi-Cal	2	4
Number of Providers Billing other Insurers	1	6
Range of Years Serving People Living with HIV/AIDS	9 – 20	10 – 20
Number of Clients Served (Range)	6 – 17,000	350 – 16,600
Number Providing Service to Other Populations	6	7
Number with OAPP Primary Funding Source	9	1
Number with Other Funding Sources	9 ²	7
Number Licensed	12	6
Number with Staff Training Plan	12	6
Number Having Annual Quality Management Plan	11	7
Number with Tracking, Evaluation, and Reporting Process	12	6
Number with Mechanism to Track Complaints and Grievances	12	7
Number with Automated Tracking of Complaints and Grievances	1	1
Number with Client Satisfaction Survey or Interviews	11	7

In addition to the findings presented in the table above, Mercer also identified valuable information on current provider practices and the challenges they face in providing quality services. These findings have been presented on the following pages in two separate sections; one for residential care providers and the other for substance abuse treatment providers.

Residential Care Provider Interview Findings

Medi-Cal Certification and Billing: Three providers were certified to bill Medi-Cal and only two were actually billing Medi-Cal for services provided to people living with HIV/AIDS. Most providers cited the complexity of Medi-Cal as a reason for not obtaining certification, as well as stating the assumption that residential care services are not covered by Medi-Cal.

² Nine of the Residential Care providers also reported having other funding sources; 3 providers had primary funding sources other than OAPP.

Most providers do not view the case management or medical services provided in the residential care settings as covered services. Only one provider was billing other insurers. One provider subcontracts for nurses and indicated the subcontractor may bill under Medi-Cal. As will be noted in Section 5 of this report, individual services provided in a residential facility may be Medi-Cal reimbursable. OAPP should partner with the DHS to assist providers in understanding and billing Medi-Cal for allowable services. It must also be noted that some of the residential providers reported that they subcontract with agencies to provide Medi-Cal reimbursable services in the residences and these subcontractors bill Medi-Cal and retain those funds.

Only two of 12 residential care providers were billing Medi-Cal. Most providers assumed services were not billable to Medi-Cal.

Range of Years Serving People Living with HIV/AIDS: The providers reported substantial experience serving people living with HIV/AIDS. The number of years of experience ranged from nine to 20 years.

Number of Clients Served: There was wide variation in the number of clients served. At the low end of the scale, one provider served six clients in a residential care setting while other providers served between 400 and 17,000 clients annually.

Percent of Clients who are People Living with HIV/AIDS: Although OAPP funds are used only for individuals with HIV/AIDS, Mercer noted wide variation in the percentage of people living with HIV/AIDS served — between one and 100 percent. The larger agencies tend to serve people other than those living with HIV/AIDS and have multiple funding sources and overlapping regulatory and reporting requirements. Of the providers interviewed, however, most specialize in residential care services for people living with HIV/AIDS. Nine of the agencies interviewed served only people living with HIV/AIDS and another three agencies reported that between 50 and 100 percent of residents served were HIV-positive.

Clients with Co-Occurring Disorders: With the exception of the children's agency interviewed, most providers reported that a substantial number of their clients had co-occurring HIV/AIDS and substance abuse disorders. Furthermore, many agencies reported serving people with multiple diagnoses — particularly those with serious mental illness, substance abuse problems, homelessness, hepatitis, and HIV/AIDS.

Most providers reported serving people with multiple diagnoses — serious mental illness, substance abuse problems, homelessness, hepatitis, and HIV/AIDS.

OAPP as the Primary Funding Source: Nine of the 12 providers interviewed reported that OAPP is their primary funding source. These nine providers reported having other funding sources in addition to OAPP. The remaining three providers reported having other primary funding sources.

Licensing: All residential service providers reported that they were licensed. The Department of Social Services Community Care Licensure provides licensing for residential services and DHS is responsible for licensing skilled nursing care facilities, such as the CLHF.

Staff Training: All providers indicated that they have a staff training plan. However, some providers reported the need for more comprehensive training — training of supervisors and more training on the changes in HIV/AIDS treatment.

Quality Management: Eleven of the 12 providers interviewed indicated they had a Quality Management Plan and could describe initiatives resulting from quality management activities.

Capacity to Track Performance: All the providers reported the capacity to track basic demographic and utilization data; however, most providers do not have an automated data collection system and must collect data manually and often from the medical records. This may be a barrier to tracking outcome data.

Mechanism to Track Complaints and Grievances: All providers reported the capacity to track complaints and grievances, although no standardized process for grievance and appeals exists across the providers. It was also noted that none of the providers currently use automated and electronic methods for tracking complaints.

Client Satisfaction Survey: Eleven of the 12 providers interviewed reported that they had a client satisfaction survey or process to identify client satisfaction.

Staffing: In general, the providers reported staffing patterns that are consistent with regulations and with the service descriptions. There was considerable discussion about staffing requirements,

In general, staffing patterns were found to be consistent with service descriptions. The emphasis on the level of nursing care required in RCFCIs was a concern.

particularly related to the level of nursing care required in the RCFCI. Several providers commented about the changing nature of HIV/AIDS disease. Clients are healthier, living longer, and are more able to address their physical needs due to the advances in HIV/AIDS treatment. However, there is a need for more supportive case management, psychiatric support, and

substance abuse counseling. Instead of CNAs, several providers recommended changes to the regulations to allow psychiatric technicians and certified substance abuse counselors to substitute for CNAs.

The providers also offered commentary on regulatory and financing barriers, which are discussed in Section 5 of this report.

Substance Abuse Treatment Providers Interview Findings

Medi-Cal Certification and Billing: Four of the seven providers are certified to bill Medi-Cal for services. It is important to note that Medi-Cal coverage for substance abuse treatment is extremely limited. Coverage includes outpatient individual and group counseling, as well as methadone dosage and counseling for the general population, but coverage of day treatment and residential rehabilitation is limited to youth receiving services as part of Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) and to pregnant and parenting women. Further, since OAPP funding is a very small percentage of total funding for all but one provider, the providers appropriately use OAPP funding for non-Medi-Cal eligible people living with HIV/AIDS.

Medi-Cal covered HIV/AIDS case management services can be provided on site, but by an agency other than the substance abuse treatment providers. These HIV/AIDS case management services were not routinely accessed by clients in substance abuse treatment.

Range of Years Serving People Living with HIV/AIDS: The providers reported substantial experience serving people living with HIV/AIDS. Experience ranged from 10 to 20 years of service provision.

Number of Clients Served: There was wide variation in the number of clients served annually. One provider served 350 clients, while another served up to 16,600. All but one of the substance abuse treatment providers are large, comprehensive treatment agencies offering a continuum of treatment services.

Percent of Clients who are People Living with HIV/AIDS: Although OAPP funds are used only for individuals with HIV/AIDS, there was wide variation in the percentage of clients who are people living with HIV/AIDS served — between six and 100 percent. The larger agencies were more likely to serve people other than those living with HIV/AIDS, have multiple funding sources, and have overlapping regulatory and reporting requirements. Of the providers interviewed, however, most specialize in substance abuse treatment services. In contrast to the responses of residential care providers, only one of the agencies' populations were all people living with HIV/AIDS.

Clients with Co-Occurring Disorders: Like the residential care providers who were interviewed, all providers reported a substantial number of their clients had co-occurring disorders of HIV/AIDS, hepatitis, substance abuse disorders, mental illness, homelessness, medical problems, etc.

OAPP as the Primary Funding Source: Only one of the seven providers interviewed reported that OAPP is their primary funding source. All others had another funding source as primary and most had multiple funding sources.

Licensing: Six of the seven providers are licensed. The single unlicensed organization offers substance abuse transitional residential care services, which is not required to be licensed under Title 9 or Title 22 of the California Code of Regulations. As long as this provider can meet the service description requirements, licensure is not of paramount importance. The provider may wish to consider licensure under the Department of Social Services Community Care Licensure requirements.

Staff Training: All but one of the providers indicated that they have a staff training plan. However, some providers reported the need for more comprehensive and up-to-date training focusing on new medical technologies, as well as important co-occurring issues like hepatitis, mental illness, and housing. Additionally, training for medical providers who treat these clients was also an important issue raised by some of the interviewees. Upon review of

Specialized staff training for providers of service to substance abuse people living with HIV/AIDS was identified as a need.

OAPP's training curriculum, it was found that training programs exist for a broad range of topics and it is likely that providers may not be optimally using these opportunities.

Quality Management: All providers interviewed indicated that they had a Quality Management Plan and could describe initiatives resulting from quality management activities.

Capacity to Track Performance: All but one of the providers reported the capacity to track basic demographic and utilization data; however, like residential care providers, most substance abuse treatment providers do not have automated data collection and must collect data manually, usually from the medical records. This may be a barrier to tracking outcome data.

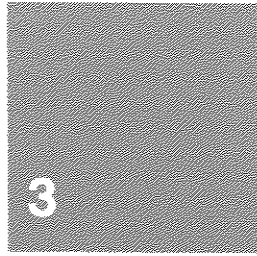
Mechanism to Track Complaints and Grievances: All providers reported the capacity to track complaints and grievances, although no standardized process for grievance and appeals exists across the providers. It was also noted that none of the providers currently use automated and electronic methods for tracking complaints.

Client Satisfaction Survey: All of the providers interviewed reported that they had a client satisfaction survey or process and most used the results as part of their quality improvement initiatives.

Staffing: In general, the providers reported staffing patterns that are consistent with regulations and with the standards in the service descriptions. There was considerable discussion about staffing standards and requirements, particularly related to the proposed Department of Alcohol and Drug Abuse Title 9 revisions. Several providers commented about the changing nature of the HIV/AIDS disease. Clients are healthier, living longer, and more able to address their physical needs due to the advances in HIV/AIDS treatment. However, there is a need for more supportive case management and psychiatric support.

In general, providers reported staffing patterns consistent with service descriptions. Using draft Title 9 standards in the service descriptions was a concern of some providers.

Substance abuse treatment providers also offered commentary on regulatory and financing barriers, which are discussed in Section 5 of this report.



RATE DEVELOPMENT

The second phase of the project involved the development of reimbursement rates for the selected categories of services using the Direct Service Staff Rate System. To understand this rate methodology, an understanding of the various cost components is critical. The cost components, and a description of each, are presented in the section below.

Cost Components

There are four standard cost components that are assumed to be common to all social and medical services. These include:

1. Direct Service Staff Wage,
2. Employment-Related Expenditures,
3. Program-Related Expenditures (not direct expenditures), and
4. General and Administrative Expenditures.

Direct Service Staff Wage

The definition of Direct Service Staff Wage consists of the following two elements:

1. The staff must be people who are performing tasks in the furtherance of the objectives of the service. In other words, they must be doing what they are doing in order to meet some objective defined in the service. They are not considered Direct Service Staff solely by their qualifications.
2. The person who is receiving the service and who is expected to benefit from it must be present, most of the time. "Most" is defined as 90 percent or more.

There is a need to be specific in the definition of Direct Service Staff because service descriptions often describe minimal amounts of time that should be spent in any given period. In some cases, this may be provided by a variety of qualifying staff. Equally, there may be staff that have the same qualifications as customary Direct Service Staff present that are not performing tasks related to the service and so would not satisfy the minimum requirements of the service standard.

Employment-Related Expenditures

Simply stated, these are all the benefits received by employees of the service agency. Benefits generally fall into two categories:

1. **Discretionary Benefits:** those benefits that employers may elect to provide but are not mandated to do so by any governmental authority.
2. **Non-Discretionary Benefits:** those benefits that are mandated by a governmental authority.

Program-Related Expenditures

These are all the expenditures that support the objectives and the provision of the service, but cannot be tied to any particular person receiving the service. For this reason, Program-Related Expenditures are considered “indirect” rather than General and Administrative Expenditures. Supervision of Direct Service Staff, supplies related to the service, consultative services to general staff, transportation, and facility costs are all examples of Program-Related Expenditures. It is important to note that many factors influence the inclusion or exclusion of cost types in this category, but the two most prominent are the service descriptions and the funding source regulations.

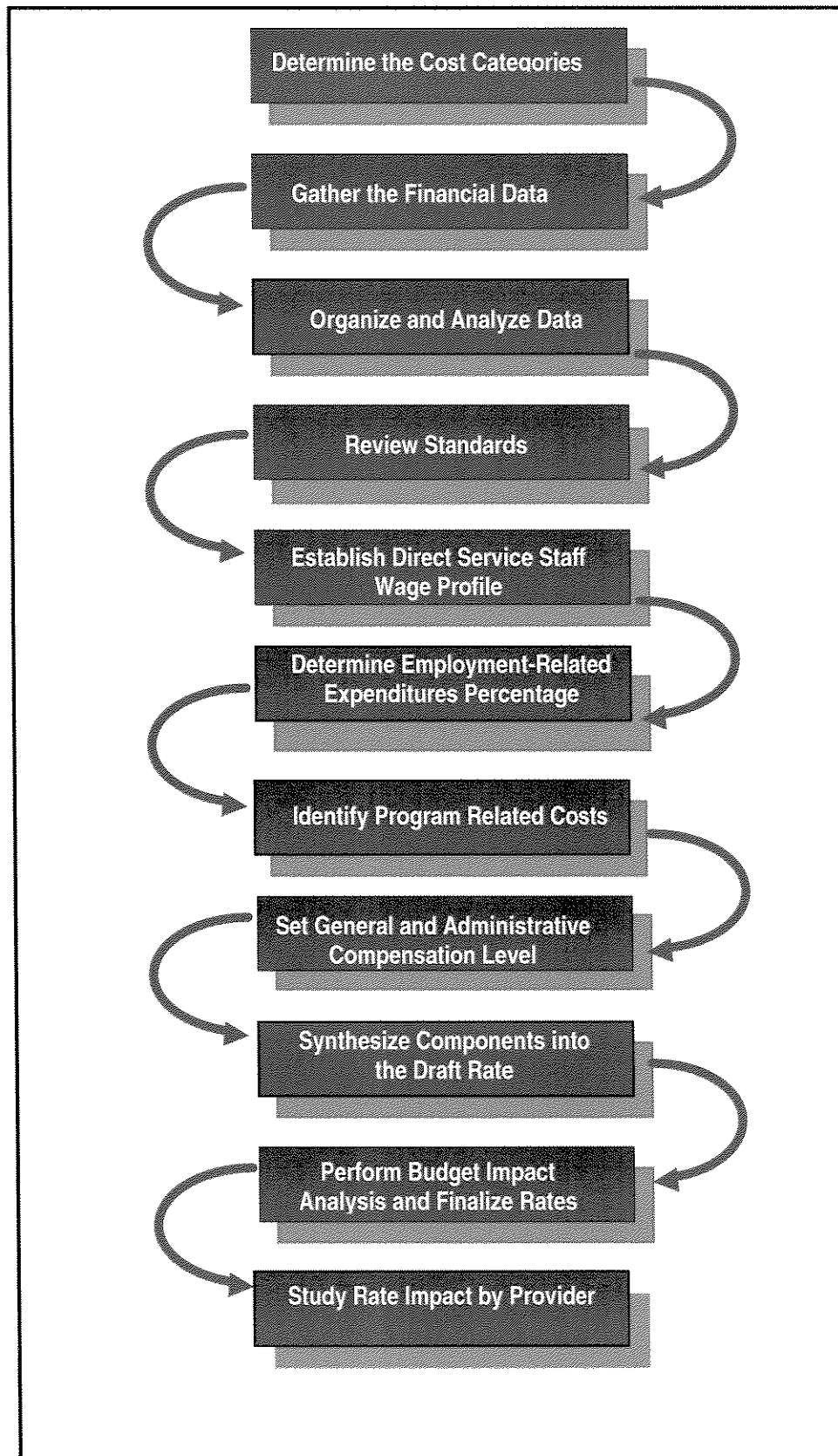
General and Administrative Expenditures

These expenditures are the costs of being in business. General and Administrative Expenditures have nothing to do with the program, the service, or the product offered. These expenditures tend to be costs that are as common to automotive manufacturing firms as they are to pizza parlors or as common to doctor’s practices as they are to amusement parks. General and Administrative expenses include administrative salaries, insurance, travel and entertainment, office expenses, program development/program director, lease or rental costs for office space, depreciation, property insurance, and other interests and equipment rental. In most instances, the categories of costs included in this component are similar in both non-profit and for-profit organizations.

Methodology

Mercer’s methodology for rate development is based on reported costs, appropriate clinical practices, and established service descriptions. This methodology has been successfully used and replicated in multiple states. The process chart on the following page provides an overview of the process, and each step is discussed in detail in subsequent sections of this report.

Rate Development Methodology — A Process Chart



The following narrative explains each step of the rate development with a description of the processes and actions taken by Mercer to successfully complete each of these steps.

Step 1: Determine the Cost Categories

The first step in developing standardized rates for residential care and substance abuse treatment services for OAPP was to study each service description in great detail to determine if the four cost categories described above will be sufficient, or if additional categories would be needed to address program and provider-specific issues.

For example, Medicaid Waiver Programs prohibit the inclusion of room and board expenditures in the set daily rates for community-based residential care facility services, but their inclusion is mandated in institutional settings. Consequently, if rates were needed for institutional settings under Medicaid, room and board charges would generally be folded into the “program-related” cost category, although there are exceptions; in community-based facilities, room and board expenditures would be broken out entirely.

Some components will vary because of differences in the way services are described. For example, in some institutional settings, nursing care is considered an integral part of the services that each resident will need and levels of nursing are expressed as requirements of the service description. In this case, a nurse would be considered a Direct Service Staff because the two parts of the definition of Direct Service Staff (furtherance of objectives and 90 percent client contact) have been met. In other settings, nursing care may or may not occur, or it may be of a consultative nature to the facility itself and not specific to any particular client. In this case, the cost of the nurse would be a part of Program-Related Expenditures.

Step 2: Gather the Financial Data

The next step undertaken by Mercer was to determine the nature, quantity, and quality of existing expenditure data for providers, as documented in the cost reports and the audited financial statements. The underlying questions that were addressed as part of this exercise were as follows (in this order):

1. Are there any line item cost reports related to the services?
2. If so, are they in enough detail so as to be identifiable in the categorizations determined necessary in Step 1?
3. If not, in what manner will the information be gathered?
4. Assuming existing cost reports, are they current?
5. Are existing cost reports reliable (i.e., do they correlate to any audited financial documents)?
6. Assuming existing cost reports, are the line items contained within them somewhat consistent between providers of the same service?

These questions were intended to establish the requirement that OAPP provider cost information reports must meet the following conditions to be useable in rate development:

- They must be available (reports must exist).
- They should be current.

- They should be accurate and objectively supportable.
- They should be in enough detail so as to allow for categorization, according to the determined categories necessary.
- Line items within them should be consistent between providers of the same service.

Based upon Mercer's analysis, it was found that OAPP provider cost reports were generally well constructed with a high degree of accuracy and consistency. It was also noted that the reports were supported through audited financials which simplified the task of financial analysis for this rate study. Because the audited financials are usually used in this step of rate development, it is customary to perform ratio analysis in this phase of the process. Ratio analysis, performed on the Balance Sheet and Income Statements, serves the purpose of assessing the general financial health of the providers. Five ratios were calculated and analyzed for the purpose of determining the ability of provider agencies in the County of Los Angeles to service debt and maintain operations at a standard of one-month availability of cash reserves. These five ratios were used to determine "going concern" status³ and are described as follows:

The OAPP provider cost reports were well constructed, consistent, and supported by audited financials, which allowed for a timely financial analysis.

Ratios for Evaluating Financial Stability

Ratio		Description
CURRENT RATIO	Current Assets-to-Current Liabilities	Short-term solvency: the ability to satisfy current liabilities with cash and disposable assets.
QUICK (ACID) RATIO	Cash and Accounts Receivable-to-Current Liabilities	Short-term solvency: similar to above but expressed at a more rigorous level.
CURRENT DEBT RATIO	Current Liabilities-to-Net Worth	A security ratio used to measure the extent that current short-term liabilities exceed net worth.
LONG-TERM DEBT RATIO	Total Liabilities-to-Net Worth	A security ratio used to measure the extent that total liability levels exceed net worth.
OPERATING RATIO	Cash and Accounts Receivable-to-One-Month of Operating Expenditures	Length of time organization could withstand a total interruption of cash flow. This is the "going concern" status ratio which ties to the 30-day standard of continuity of care.

The results of the liquidity analysis and the application of the calculations related to these ratios indicate that generally, the providers of the services included in the study met the conditions for "going concern" status.

³ "Going concern" status is an accounting term defined in General Accounting Principles that means the organization is not in danger of closure or bankruptcy.

Step 3: Organize and Analyze Data

In this step, OAPP cost report information was organized so that the cost components could be compared in a consistent manner across providers. This organization of the information allowed for the successful completion of the component analysis. The final result of the component analysis was a true understanding of each of the cost components' relationship to Direct Service Staff costs for each of the service categories analyzed. Additionally, these components were expressed in terms of that relationship (usually as a percentage).

Phase 4: Review Standards

In the fourth step of development, Mercer reviewed the service descriptions prepared in the first phase of the study to establish the proper type and quantity of Direct Service Staffing levels and the general profiles of the Direct Service Staff specific to the service description. This information formed the basis of the completed rates.

The standards were written to identify Direct Service Staff needs and requirements.

Step 5: Establish Direct Service Staff Wage Profile

Mercer then proceeded to establish the wages associated with the staff described in the service descriptions as Direct Service Staff. Depending on the unique nature of the service being studied, this can be performed in a number of ways. Wage and Benefit studies can be performed, research into objective sources of wage and benefit information (such as the Bureau of Labor Statistics) can be done, prevailing market wages currently paid by providers in the area can be reviewed, and finally, administrative discretion may be used to set wage levels as a matter of policy. For this particular study, Mercer used the Bureau of Labor Statistics to establish Direct Service Staff wage levels, since Los Angeles-specific and detailed information across all relevant staffing levels was available through this source. Details regarding the wages are presented on page 23 of this report.

Step 6: Determine Employment-Related Expenditures Percentage

Mercer calculated the Employment-Related Expenditure percentage. This was done by comparing the percentage revealed by the analysis of the cost reports to known information about benefit percentages. As with the wage levels, a decision was needed whether to use the existing market percentage in the current providers' cost reports, or whether to use an objectively determined "fully loaded" benefits package as might be available from an objective source, or to set this percentage by administrative discretion as a matter of policy. For this study, Mercer chose to use the existing market percentage identified in the analysis of the most current OAPP providers' cost reports.

Step 7: Identify Program-Related Costs

Mercer isolated all accounts from provider cost reports that were identified as program-related. Then the amounts in those cost line items were totaled and compared to direct care staff costs in order to derive a percentage that expressed the relationship. That percentage was then used to reconstruct the new rates based on the new direct service staff profiles.

Step 8: Set General and Administrative Compensation Level

It is important to include a brief discussion about General and Administrative Expenditures in the description of this step of rate development. General and Administrative Expenditures are almost always and almost completely “fixed” in nature, which means that they do not vary in periods of less than one year. General and Administrative Expenditures are not related to the type of business (service or product) that the company provides. However, this kind of cost component is extremely sensitive to scale. This implies that if a provider does a lot of business, the percentage will be low and if a provider does very little business, the percentage will be high. But if the cost is expressed as a percentage, that percentage will be very different at every level of business activity. It also means that two organizations with exactly the same dollar amount of General and Administrative Expenditures, but with very different general levels of business will have very different General and Administrative percentages.

This creates a dilemma for rate setting because it must be standardized. If it is not expressed as a single percentage, it results in a very complicated rate system. Fortunately, most government-funding agencies set General and Administrative reimbursement levels by policy and express the compensation limit as a single percentage.

To determine the appropriate General and Administrative percentage for the rate system, Mercer conducted interviews and discussions with HRSA, as well as with OAPP. As explained by HRSA staff, OAPP is permitted to compensate provider agencies for General and Administration Expenditures but only up to a maximum of 10 percent across all provider agencies. In other words, General and Administration percentage funding cannot exceed 10 percent for the entire system. It is permitted to compensate individual provider agencies at different General and Administration percentage levels provided that the entire dollar expenditure in this category, taken across all provider agency activity, does not exceed 10 percent.

Based on this information, a General and Administrative percentage of 10 percent was used in the rate development process. The Direct Service Staff wage plus the Employment-Related Expenditure plus the Program-Related Expenditure constitutes a subtotal (subtotal 1), which is adjusted for the General and Administrative by “grossing up” the total by the General and Administrative percentage such that:

$$\text{Subtotal 1 divided by } (1 - \text{General and Administrative Percentage}) = \text{Total Rate}$$

If a single series of published rates is created (one for each service line), the 10 percent calculation is embedded in the calculations for all rates. At the end of the year when reporting requirements obligate OAPP to demonstrate the nature and details of the expenditures, the 10 percent becomes a simple calculation, and with the exception of very minor rounding error, the number will be exact. That is because the dollar amount was always calculated at 10 percent within the actual rates paid.

The General and Administrative percentage is also the variable that can be varied to create and pay separate levels of rates based on provider agency size or scale, provided that the 10 percent figure is not exceeded for the entire system (not for any given provider or service line).

Further discussion on the provider scale issue and its impact on the rates have been presented in the budget impact section of this report.

Step 9: Synthesize Components into Draft Rate

In this step, all the numbers obtained through the previous steps were combined and reassembled using the base wage for the Direct Service Staff and the appropriate percentages for the other cost components. The mathematic calculations that serve as the basis for the rates were performed in Microsoft Excel and the final rates that emerged as a result of these calculations are presented in the form of tables for residential care and substance abuse treatment services.

Step 10: Perform Budget Impact Analysis and Finalize Rates

After the rates for the specific categories of service were prepared in draft and reviewed with OAPP and the Department of the Auditor-Controller, Mercer proceeded to perform a budget impact analysis to study the effect of the rates on the existing service budget for OAPP.

Step 11: Study Rate Impact by Provider

For HIV/AIDS residential care and substance abuse treatment services in the County of Los Angeles, different rates have developed over long periods of time with different negotiation characteristics. In such an environment, if these varying rates are replaced with a standardized published rate system for the very same services and for the very same providers and recipients, some providers will see increases and some may see decreases in reimbursement rates. For this reason, Mercer studied the impact of the rate system on each provider to determine the amount of increase or decrease they will experience. Mercer recognizes that beyond a certain level, a decrease could be devastating to a provider and would jeopardize their financial health. The loss profile of the individual providers is studied to determine if any are at intolerable risk of loss. For providers whose potential loss exceeds what would be considered tolerable, the loss can be

The impact of implementing the proposed rates was studied in regards to the overall budget and specific to each provider.

“stopped” at some level considered acceptable. Correspondingly, any increases that exceed the same level can also be “stopped” to keep the entire system in balance in a process referred to as “banding the loss.” Additionally, the rate structure assumes that increasing other sources of revenue, including Medi-Cal, can mitigate the negative impact that the rates may have on some of the providers and the effort to maximize funding from these alternate sources is strongly encouraged.

The analytical methodology used to complete the budget impact and provider impact analysis, as well as the summary findings and observations of this analysis are presented in the subsequent chapter of this report.

Adjustment Factors

Adjustment factors are those elements that might change in the rate system after it has been introduced. It is important to note that in any FFS rate system, changes that occur in the financial environment that directly relate to the components of the rate system do not automatically initiate a change in the established rates.

Wage levels change every year and may become out-of-date. “Unfunded mandates” are usually not at the discretion of either the providers or the funding agency (unemployment insurance rates, workers’ compensation, etc.).

The most notable adjustment factor relevant to this particular HIV/AIDS rate study is the adjustment based on size of the provider organization. The provider interviews and evaluations of cost reports indicated that there is considerable variation in size among the various residential and substance abuse providers. Based upon the review, as well as Mercer’s experience in other environments, the rate component that is most likely to vary with scale is the percentage of General and Administrative expenses. This is because this category accounts for the majority of the fixed costs for any provider and is most responsive to scale/size considerations. Mercer has developed adjustments to the proposed rate, which if OAPP desires, may be used to ensure that smaller providers are not placed at an undue competitive disadvantage. These adjustments are comprised of differences in General and Administration percentages and the dollar value of the adjustments are presented in the subsequent section of this report.

Changes in service descriptions can have a profound influence on the continued accuracy of the published rates.

Adjusting rates for issues noted above, and the timing of rate changes, are policy decisions made by the funding agency.

Future Rate Change Process

Pressure to revise the rate amounts can and will occur without the necessity to change the architecture of the rate system itself. The system is adaptable to change by appropriate adjustments to the calculations within the system. Mercer has provided OAPP with the detailed rate modeling analytical files in Microsoft Excel that allows for adjustments to various rate components, which will result in automatic recalculation of rates. Some areas where changes could occur are as follows:

- If political will exists to increase the assumption of Direct Service Staff Wage levels and the decision to increase them is made and funded, the wage levels can be immediately changed and the rates will automatically recalculate.
- If unfunded mandates become funded, those changes can be made to the appropriate component (usually Employment-Related or General and Administrative Expenditures) and again, the rates will automatically recalculate.
- Service descriptions will usually either affect the Direct Service Staff profile or the Program-Related Expenditure percentage. If so, these may involve a more complicated recalculation of the rate system components but the architecture remains unchanged.

Findings and Results

Based upon the methodology outlined in the sections above, Mercer has successfully achieved the primary goal established for this study, namely, the creation of a clinically-valid, actuarially-

sound rate system for residential care and substance abuse treatment services for people with HIV/AIDS in the County of Los Angeles. The key rate-associated results of this study are presented below.

Determination of Cost Categories

Upon review of the provider cost reports, Mercer determined that the various costs outlined in the reports could be categorized into the four standard cost categories. The only costs that were determined to be distinct and, therefore, requiring a separate category were the Facility-Related charges. The rate system has been designed for OAPP residential care and substance abuse treatment providers to be fully Medi-Cal compliant in the context of Home- and Community-Based Waivers. For this reason, all facility costs, including food and food preparation, have been pulled out of cost profiles and compensation levels set separately.

Financial Stability/Ratio Analysis

The five ratios that were evaluated to assess the financial health and stability of the providers were as follows:

- **CURRENT RATIO:** Current Assets-to-Current Liabilities,
- **QUICK (ACID) RATIO:** Cash and Accounts Receivable-to-Current Liabilities,
- **CURRENT DEBT RATIO:** Current Liabilities-to-Net Worth,
- **LONG-TERM DEBT RATIO:** Total Liabilities-to-Net Worth, and
- **OPERATING RATIO:** Cash and Accounts Receivable-to-One Month of Operating Expenditures.

Detailed, analytical spreadsheets were provided to OAPP based on the review of the audited financials. These are not included in this report due to the proprietary and confidential nature of the provider-specific financial information. However, the results of the liquidity analysis and the application of the calculations related to these ratios indicate that generally, the providers studied, both for residential care and substance abuse treatment services, were within reasonable limits of financial health and stability.

Establishment of Staff Wage Levels

Sufficient wage level information was provided in the Bureau of Labor Statistics reports to trend the wage levels forward to the year 2003. The information used was specific to the County of Los Angeles, and those staff categories were selected that best reflected the requirements of the standards. These wage levels are summarized in the table below.

Bureau of Labor Statistics for the County of Los Angeles⁴

Year	Counselor	Registered Nurse	Social Worker	Psychologist	Recreation Worker	General Health Related	Nurse Assistant
1998	\$27.68	\$24.56	\$20.09	\$28.70	\$12.98	\$25.72	\$8.57
1999	\$27.43	\$24.61	\$21.71	\$31.66	\$13.86	\$26.26	\$8.54
2000	\$27.31	\$24.97	\$21.48	\$30.86	\$14.03	\$27.25	\$8.88
2001	\$30.60	\$27.02	\$23.12	not available	\$16.23	\$30.15	\$9.77
2002	\$33.90	\$29.56	\$24.41	not available	\$15.47	\$30.40	\$10.16
2003*	\$35.46	\$30.81	\$25.49	\$34.10	\$16.09	\$31.57	\$10.56

*Trended to 2003.

Rate Component Calculation

From OAPP provider financial reports, the Bureau of Labor Statistics, and the staff levels identified from the service descriptions, Mercer was in a position to complete the rate analysis to quantify the various cost components involved in the creation of the Direct Service Staff Rate System. Certain assumptions were made when completing the analysis and calculations. These assumptions must be kept in mind when interpreting the results of the analysis and are presented in the following chart:

Key Assumptions Used in the Rate Calculations

- It was assumed that the goal of OAPP was to simplify the varied and complicated rates that are currently in place by creating a single rate for each defined service category based on established service descriptions.
- It was assumed that the Provider Agency Cost Reports and Contract Schedules collected by OAPP and provided to Mercer are reasonably accurate and are, therefore, usable for the development of rates.
- It was assumed that the wage levels available for the County of Los Angeles through the Bureau of Labor Statistics were accurate and an expensive and prolonged wage and benefit analysis was not required.
- It was assumed that the General and Administrative expenses for the providers would be capped at 10 percent, per federal, state, and local regulations and guidelines for funding of care services.
- It was assumed that the average room and board rate of \$22.00 per day was reasonable and appropriate for use in the rate development process. This rate was determined from a combination of information obtained from provider cost reports and from comparisons with federal supplemental security income (SSI) assumptions for daily income. For Residential Emergency Housing, Residential Transitional Housing services and Substance Abuse Transitional Housing, expenditures related to food and meal preparation were not included in the room and board rate assumption. It is assumed that this accurately reflects the expenditure patterns in these settings.
- For services where service descriptions prescribed the use of a qualified health professional without specifying the level of training and qualifications needed, a general health professional wage category from the Bureau of Labor Statistics was used in determining direct service costs. For Residential Emergency Housing, Residential Transitional Housing, and Substance Abuse Transitional Housing, a different employment category expressed by the Bureau of Labor Statistic was used. This category reflects the skill set for positions referred to as "Nurse Assistants" and "Attendants." It is assumed that this accurately reflects the expenditure patterns in these settings.

⁴ Source: U.S. Department of Labor, Bureau of Labor Statistics Data, National Compensation Survey, Los Angeles, Riverside, and Orange Counties.

Based upon these assumptions and through the analytical steps outlined previously, Mercer calculated the various cost components that go towards the creation of the Direct Service Staff rate system. These components are summarized in two subsequent tables, one for residential care services and the other for substance abuse treatment services.

Rate Component Table for Residential Care Services

Cost Component	ARF	RCFCI	GH	CLHF + Hospice	Emerg. Housing	Trans. Housing
Blended Hour Wage	\$23.83	\$26.42	\$23.83	\$30.75	\$18.03	\$ 10.56
Employment-Related Expenses	40.37%	40.37%	40.37%	40.37%	40.37%	40.37%
Program-Related Expenditures	59.66%	70.71%	82.90%	82.09%	59.48%	59.48%
General and Administrative	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%
Proposed Service Rate	\$107.34	\$125.59	\$108.38	\$392.26	\$ 25.86	\$ 11.38
Room and Board	\$ 22.00	\$ 22.00	\$ 22.00	\$ 22.00	\$ 16.94	\$ 16.94
Total Rate	\$129.34	\$147.59	\$130.38	\$414.26	\$42.80	\$28.32
Current Rate Range	\$98.00 – \$125.00	\$113.00 – \$135.00	\$124.52	\$425.00	\$35.00	\$25.00 – \$44.00

Note: Each service uses a different “mix” of Direct Service Staff based on the professions and job categories identified in the standards (Counselor, Nurse, Social Worker, Psychologist, General Health, Recreation Staff). Some services will use a greater proportion of medically-trained staff than others. The Blended Hour Wage reflects this mix for each service. Although each of these service categories was reviewed by Mercer and a rate was developed, not all services may be purchased in the future by OAPP. Please see Section 6 for recommendations.

Rate Component Table for Substance Abuse Treatment Services

Cost Component	Day Tx	Detox	Methadone	Res. Rehab - Low	Res. Rehab - Medium	Res. Rehab - High	Trans. Housing
Blended Hour Wage	\$29.54	\$33.40	\$35.46	\$26.15	\$26.15	\$26.15	\$10.56
Employment-Related Expenses	40.37%	40.37%	40.37%	40.37%	40.37%	40.37%	40.37%
Program-Related Expenditures	59.66%	54.75%	72.47%	66.79%	66.79%	66.79%	66.79%
General and Administrative	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%	10.00%
Proposed Service Rate	\$43.76	\$217.21	\$50.32	\$36.11	\$60.18	\$90.27	\$ 23.33
Room and Board	\$0.00	\$22.00	\$0.00	\$22.00	\$22.00	\$22.00	\$ 16.94
Total Rate	\$43.76	\$239.21	\$50.32	\$58.11	\$82.18	\$112.27	\$ 40.27
Current Rate Range	\$35.00	\$225.00	\$51.12	\$69.35 - \$112.00			\$18.00 - 24.20

Note: Each service uses a different "mix" of Direct Service Staff based on the professions and job categories identified in the standards (Counselor, Nurse, Social Worker, Psychologist, General Health, Recreation Staff). Some services will use a greater proportion of medically-trained staff than others. The Blended Hour Wage reflects this mix for each service. It must also be noted that the Substance Abuse Transitional Housing assumptions changed after the preparation of the budget impact analysis resulting in the rate of \$40.27 presented in the table. Because of the intensity of the analytical process and since the change represented a reduction in the rate, the budget impact analysis was not adjusted. The difference (1% of the total OAPP budget) is preserved as a budgetary buffer. Although each of these service categories was reviewed by Mercer and a rate was developed, not all services may be purchased in the future by OAPP. Please see Section 6 for recommendations.

Observations Regarding the Rates

Some important issues were revealed through the rate analysis and calculations. These observations highlight policy decisions that may need to be made in the implementation of the rate architecture. The key observations are discussed in the section below.

General Observations

- In general, the proposed rates in most service categories evaluated in this study were found to be higher than the current rates. The two exceptions were for CLHF + Hospice and substance abuse methadone treatment. The increase in rates is primarily due to higher wage levels and changing staffing needs as a result of the new standards and emerging trends in HIV illness and treatment.
- For all the rates, an Employment-Related Expense percentage of 40.37 percent was utilized. This percentage was derived from the most current OAPP providers' cost reports and is more generous than standard benefit packages in the health care industry. It must be noted that this represents all Employment-Related Expenditures expressed as a percentage of only Direct Service Staff changes.
- There were noteworthy differences between the services with regard to program related percentages (derived from cost reports), as well as staffing mix (as indicated in the service descriptions). In most service categories this is intuitive and is normally expected. In the case of transitional housing, however, the service might be expected to have similar rates because the service might be assumed similar, if not identical, between Residential and Substance Abuse categories. This does not hold true. There are very significant differences between the Residential and Substance Abuse transitional housing services related to the staffing mix as well as the program related percentages. These differences are reflective of the true differences between the settings in which the service occurs.

Residential Care Services

- Current rates for providers within the same category of service currently vary significantly.
- Since a general health professional wage category was used in calculating the Direct Service Staff levels for ARFs, RCFCIs, GHs, and CLHFs, the blended hourly wage is higher for these categories. This was done to address the issue of changing service needs of patients and to allow providers the opportunity to hire appropriately-qualified staff to provide new and more complicated services that may not be adequately managed through the use of CNAs. For the other service categories, the staff levels assume the use of CNAs to perform the non-specific general care services.

- Currently, some providers are paid more for ARF services than for RCFCI, even though existing and new service descriptions identify the RCFCIs as a higher level of care. This has been corrected through the proposed rate structure.
- While currently the rates for Residential Transitional Housing and Residential Emergency Housing are fairly similar, the rates that have been proposed as part of this study are significantly different. Because of the assumption that the high turnover of patients with acute and immediate support needs within Residential Emergency Housing results in added social support staffing needs, the rate for this category (\$42.80) is higher than that of Residential Transitional Housing (\$28.32) where patients are staying for longer periods and are likely to be more stable in terms of linkages to other support services.
- According to California DHS staff, the Medi-Cal rate for Residential Hospice is \$140.46. The current rate paid to the single HIV/AIDS CLHF provider is \$425.00, which is more in line with inpatient Hospice rates. In the Hospice environment, there is a growing trend towards more home-based supportive Hospice care with decreasing need for high clinical intensity facility-based Hospice services. This is also the case in HIV/AIDS-related Hospice, where the evolving nature of the epidemic resulting from dramatically improved treatment options has resulted in decreased need for high-intensity care. In addition, virtually all clients needing this service are eligible for Medi-Cal or Medicare and therefore OAPP funds a limited number of clients not covered by this funding source.

Substance Abuse Treatment Services

- Current rates for providers within some of the same categories of substance abuse services vary significantly.
- For residential rehabilitation services, the current OAPP rates do not distinguish between the levels of intensity of rehabilitation services. Hence, a single rate range is shown for that category. However, the Department of Alcohol and Drug Programs is promulgating new rules that clearly define three levels of services — high, medium, and low — and has developed clear differences in standards of care for these levels. To allow OAPP to align its rates to these new rules, Mercer created three proposed rates, one for each intensity level within residential rehabilitation services. For each of these three rates, the table shows the same numbers for the four rate components (Blended Hour Wage, Employment-Related Expenditure, Program-Related Expenditure, and General and Administrative). The final rate differences for each category of residential rehabilitation, however, results from the mathematical calculations associated with the Direct Service Staff-to-client ratio — the high intensity residential rehabilitation providers requiring a higher number of Direct Service Staff, as compared to the lower intensity residential rehabilitation providers to manage the same number of residents. In accordance with the draft rules being promulgated by the Department of Alcohol and Drug Programs, the determination of placement in low, medium, or high intensity substance abuse residential placement must be based on a standardized, industry-accepted assessment tool such as the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPCII) during the participant assessment process⁵.
- In the initial evaluations of cost reports, the Program-Related Expenditures for substance abuse transitional housing (95 percent) were found to be far greater than any other service

⁵ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

and significantly higher than expected for this type of service (for residential transitional housing, this percentage was found to be 59.48 percent). While the precise cause of this high percentage cannot be determined without an in-depth analysis of provider-specific cost accounting processes, it is speculated that classification differences in the provider cost reports could be occurring which would cause certain facility-related expenditures to remain in this cost component category. After discussions with the County of Los Angeles, it was decided that the same percentage for program-related expenses calculated for substance abuse residential rehabilitation services (66.79 percent) would be most appropriate to use for substance abuse transitional services. This would take into account the higher Program-Related Expenditures that are likely to be associated with substance abuse-related services, as compared to residential transitional housing.

- Current transitional housing rates are uniformly low across all the providers in this category. However, based on the analysis of service standards and regulatory requirements, it was determined that current funding is not aligned with the resource-intensity of services provided in these facilities. For this reason, the increases in transitional housing rates proposed as a result of this study are significant.
- The rate for Methadone is limited specifically to outpatient Methadone counseling and is presented as an hourly rate, hence, differing significantly from the per diem rates in all other service categories. Out of two providers initially identified within this service category, interviews revealed that one provider had recently terminated its contract with OAPP, and the other was also intending to end its contract for this particular service in 2004. For this reason, it is believed that this category may be eliminated from future procurements, although a proposed rate for the service was developed based upon the service description and cost analysis.

Impact of Provider Size and Scale on the Rate System

General and Administrative costs in the architecture of the rate system proposed represent primarily fixed costs. Fixed costs are those that do not change in accounting periods of less than one year (sometimes much longer). Because the needs of administration are present with almost every size organization, and the dollar amounts do not change, if those dollar amounts were to be expressed as a percentage of over all expenditures, the percentages would vary significantly between agencies of different sizes. Consequently, what may be a small General and Administrative percentage for a very large organization would end up calculated as a very high percentage for a small organization because the costs expressed as dollars may be very similar. The other cost groups within this rate architecture are far more variable (and also those referred to as “stepped variable”). These costs vary as the staffing changes and the number of recipients of the service change. Consequently, they are not fixed, and differences in the size of the organization do not cause large differences in these costs when expressed as a percentage of overall costs.

When producing rate differentials to correctly fix the General and Administrative costs to a certain size of an agency, it is the General and Administrative percentage that is manipulated to accomplish the differential. As a result of HRSA information, it is possible to create tiers of General and Administrative percentage based on size so as to respond to scale pressures. However, it is important to note that this introduces variability in overall General and

Administrative Expenditures for the system. As the mix of activity between agencies of different sizes changes, the overall General and Administrative percentage will change based on the different percentages paid to provider agencies of different sizes.

Mercer used its experience in the development of capacity-based adjustments in other environments, as well as an assessment of the size of County providers included in this study, in creating three groups based on total bed capacity. These groups are:

- **Small** – 10 or less beds,
- **Medium** – 11 to 100 beds, and
- **Large** – 101 or more beds.

The following table presents the calculations related to scale differentials. The “Base Rate” presented in the central column of the table, represents the originally-proposed rate that would be implemented should no scale differentials be adopted. From the base rate, an increase is added to accommodate small providers and a decrease is taken to adjust to the economies of scale of larger organizations. These differentials are entirely the result of General and Administrative calculation differences. For the average-sized provider the General and Administrative percentage is 10 percent of the total rate. For a small provider the General and Administrative costs represent 12 percent of the total rate. For large providers the General and Administrative costs represent 9 percent of the overall rate. Size is measured by the total number of beds available to residents (clients) regardless of funding.

Scale Adjustment Calculations

Service Category	Small 1 to 10 Differential	Rate	Medium 11 to 100 Base	Large 101 + Differential	Rate
Residential Care (Chronically Ill)	\$2.86	\$150.45	\$147.59	(\$1.38)	\$146.21
Residential (CLHF)	\$8.91	\$423.16	\$414.26	(\$4.32)	\$409.94
Residential (GH)	\$2.46	\$132.84	\$130.38	(\$1.19)	\$129.19
Residential (ARF)	\$2.44	\$131.78	\$129.34	(\$1.18)	\$128.16
Residential (Emergency Housing)	\$0.59	\$43.39	\$42.80	(\$0.28)	\$42.52
Residential (Transitional Housing)	\$0.25	\$28.57	\$28.32	(\$0.13)	\$28.19
Substance Abuse (Detox)	\$4.94	\$244.15	\$239.21	(\$2.38)	\$236.83
Substance Abuse (Res. Rehab – Low)	\$0.82	\$58.93	\$58.11	(\$0.40)	\$57.71
Substance Abuse (Res. Rehab – Medium)	\$1.37	\$83.55	\$82.18	(\$0.66)	\$81.52
Substance Abuse (Res. Rehab - High)	\$2.06	\$114.33	\$112.27	(\$0.99)	\$111.28
Substance Abuse (Trans. Housing)	\$0.53	\$40.80	\$40.27	(\$0.25)	\$40.02

Note: Size is measured in terms of the total number of beds

4

Budget Impact Analysis

In any rate development exercise, the importance of evaluating the impact of the rates on the program budget at the existing level of funding cannot be overemphasized. Additionally, it is also critical to assess and seek to quantify the impact of the rates on the individual providers.

This is especially important for HIV substance abuse and residential care services in the County of Los Angeles, where different rates have been developed over long periods of time, with different negotiation characteristics. In such an environment, the replacement of these variable rates with a standardized published rate system will result in increases in rates for some providers while others may see

Impact of new rates on current program budget and on individual providers requires a detailed analysis.

decreases in reimbursement rates. For this reason, Mercer performed an in-depth budget analysis to study the impact of the rate system on each provider to determine the amount of increase or decrease they will experience. Mercer recognizes that beyond a certain level, a decrease could be devastating to a provider and would jeopardize their financial health; it could even put them out of business. As previously noted, however, the rate structure does assume that increasing other sources of revenue, including Medi-Cal, can mitigate the negative impact that the rates may have on some of the providers.

Methodology

The process used to perform the Budget Impact Analysis for Los Angeles County consisted of the following steps:

- **Establish existing budget (by provider):** This was done by determining contracted and capacity bed-day levels and current contracted or equivalent rates.
- **Establish proposed rates:** For services where standards prescribed the use of a qualified health professional without specifying the level of training and qualifications needed, a general health professional wage category from the Bureau of Labor Statistics was used in determining the blended direct service costs. However, through provider interviews, it was determined that due to budget constraints, providers use CNAs to perform the services required of this level of staff. For this reason, two rate systems were created for review. The first assumes a blended General Medical basket of Direct Service Staff skill sets as available in residential provider environments. The second replaces this group with a single assumption of the use of CNAs and Medical Attendants. In early discussions of the findings with OAPP and the Department of the Auditor-Controller, a decision was made to use the

rates based on higher wage assumptions in all but two residential service categories. For emergency housing and residential transitional housing, the use of CNAs was assumed within the wage mix, since based on the existing standards and service descriptions, a lower intensity of care services are required in these facilities. The use of CNAs within the staffing mix was also assumed while developing rates for substance abuse transitional housing.

- **Calculate budget variance:** Mercer calculated the difference between current rates and total budgets to the proposed rates and the resulting budgets if contracted bed days were to be paid at proposed rates.
- **Calculate potential adjustments:** The percentage adjustment to the proposed rate that would be necessary to maintain budget neutrality throughout implementation of the proposed rates was determined. This was performed in two ways. The first analysis compared the proposed budget to the existing budget across all services (residential care and substance abuse). The second, and recommended approach, isolated separate budget impacts for residential care and substance abuse and applied discreet adjustment factors for each.
- **Measure impact on individual providers:** The impact of the proposed rate system on each individual provider agency was then calculated and expressed in total dollar amounts, as well as by percentage.
- **Perform impact analysis at full capacity funding:** One of the concerns expressed by OAPP was the issue of bed-capacity for the providers, since many providers have more beds than those funded through OAPP. To understand the relationship of bed capacity to the rates, Mercer completed a comparison of current budget to the budget implied by the full funding of the capacity for each provider wherever bed capacity information was available. The primary objective of this analysis was to ensure that the rate recommendations were based on the reality that other funding sources are available and need to be optimally used to finance excess bed-capacity that is not supported through OAPP funds.

Findings and Results

Completion of these steps resulted in exhaustive and complex Microsoft Excel data modeling files and spreadsheets that were shared with the senior staff at OAPP. It must be noted that for substance abuse transitional housing, assumptions changed after the preparation of the Budget Impact Analysis resulting in a proposed rate for that service of \$40.27. Because of the intensity of the analytical process and since the change represented a reduction in the rate, the budget impact analysis was not adjusted and instead uses the original rate of \$57.55. The difference (1% of the total OAPP budget) is preserved as a budgetary buffer. Three summary tables that highlight the impact of the new rates by service category and present a few options for implementation that will maintain budget neutrality are presented on the following pages. Following these tables a few salient findings are also discussed in more detail.

Budget Impact at the Proposed Rates

Service Category	Current Rate	Initial Proposed Rate	Total Dollar Impact	Current Funded Capacity Bed Days	Budget Change %
(↓) = decrease (↑) = increase					
Residential (Chronically Ill)	\$113.00 - \$135.00	\$147.59	\$977,559	34,821	19.3% (↑)
Residential (CLHF)	\$425.00	\$414.26	(\$44,013)	4,015	(2.6%) (↓)
Residential (GH)	\$124.52	\$130.38	\$14,972	2,555	4.5% (↑)
Residential (ARF)	\$98.00 - \$125.00	\$129.34	\$194,415	8,030	18.8% (↑)
Residential (Emerg Housing)	\$25.00 - \$35.00	\$42.80	\$40,385	3,650	25.9% (↑)
Residential (Trans Housing)	\$25.00 - \$44.00	\$28.32	(\$53,453)	8,578	(21.9%) (↓)
TOTAL RESIDENTIAL			\$1,129,865	61,649	13.23% (↑)
Substance Abuse (Day Tx)	\$35.00	\$43.76	\$5,466	1,825	20.0% (↑)
Substance Abuse (Detox)	\$215.00 - \$291.00	\$239.21	\$19,806	2,555	3.7% (↑)
Substance Abuse (Res. Rehab)	\$69.00 - \$126.00	\$82.18 / \$112.27	\$68,429	16,608	4.2% (↑)
Substance Abuse (Trans Housing)	\$18.00 - \$24.20	\$57.55	\$261,665	6,935	64.5% (↑)
TOTAL SUBSTANCE ABUSE			\$355,366	27,923	13.6% (↑)
TOTAL ALL SERVICES			\$1,485,231	89,572	13.3% (↑)

Note: Current Funded Capacity Bed Days is the number of beds specified in the provider contract multiplied by 365.

Budget Impact: Rates Adjusted by Service Group

Option One: Adjust Rates by the Service Group Percentage	Current Rate	Initial Proposed Rate	Rate Adjusted to Service Group	Total Dollar Impact at Group Adjusted	Capacity Bed Days at Group Adj. Rate	Rate Change %
Residential Care (Chronically Ill)	\$113.00 - \$135.00	\$147.59	\$128.06	\$305,902	34,391	13.23 %
Residential (CLHF)	\$425.00	\$414.26	\$359.45	(\$268,624)	4,098	13.23 %
Residential (GH)	\$124.52	\$130.38	\$113.13	(\$29,101)	2,555	13.23 %
Residential (ARF)	\$98.00 - \$125.00	\$129.34	\$112.23	\$57,894	7,979	13.23 %
Residential Emerg. Housing	\$25.00 - \$35.00	\$42.80	\$37.14	\$19,766	3,643	13.23 %
Residential Trans. Housing	\$25.00 - \$44.00	\$28.32	\$24.57	(\$85,838)	8,636	13.23 %
TOTAL RESIDENTIAL				(\$1)	61,302	13.23 %
Substance Abuse (Day Tx)	\$35.00	\$43.76	\$37.83	\$1,766	624	13.56 %
Substance Abuse (Detox)	\$215.00 - \$291.00	\$239.21	\$206.78	(\$53,389)	2,257	13.56 %
Substance Abuse (Res. Rehab)	\$69.00 - \$126.00	\$82.18 / \$112.27	\$71.04 / \$97.05	(\$155,061)	16,608	13.56 %
Substance Abuse Trans. Housing	\$18.00 - \$24.20	\$57.55	\$57.55	\$206,667	7,051	13.56 %
TOTAL SUBSTANCE ABUSE				(\$17)	26,540	13.56 %
ALL SERVICES				(\$18)	81,449	13.31 %

Note 1: Rounding of numbers results in negligible dollar values for the total dollar impact for the service groups and the overall budget impact through this option may be considered zero. **Note 2:** The unit of services for outpatient Methadone service rate is an hourly rate for counseling, as compared to a per diem rate for the other services in the group, hence, a budget impact for this category could not be performed. Since funding for this category is limited, the impact on OAPP budget will be negligible.

Budget Impact: Rates Adjusted by Service Line Percentage

Service Category	Current Rate	Initial Proposal	Rate Adjusted to Service Line
RESIDENTIAL CARE SERVICES			
Residential Care (Chronically Ill)	\$113.00 – \$135.00	\$147.59	\$119.17
Residential (CLHF)	\$425.00	\$414.26	\$425.00
Residential (GH)	\$124.52	\$130.38	\$124.52
Residential (ARF)	\$98.00 – \$125.00	\$129.34	\$104.97
Residential (Emerg Housing)	\$25.00 – \$35.00	\$42.80	\$31.71
Residential (Trans Housing)	\$25.00 – \$44.00	\$28.32	\$34.51
SUBSTANCE ABUSE SERVICES			
Substance Abuse (Day Tx)	\$35.00	\$43.76	\$35.00
Substance Abuse (Detox)	\$215.00 – \$291.00	\$239.21	\$230.43
Substance Abuse (Res. Rehab)	\$69.00 – \$126.00	\$82.18 / \$112.27	\$78.77 / \$107.61
Substance Abuse (Trans. Housing)	\$18.00 – \$24.20	\$57.55	\$20.44

Note: Budget impact, when adjusted to individual service line or category, will be zero. Additionally, the adjustment will result in rates that are close to the current rates in those categories where only one provider exists in a service category.

The budget impact analyses that is summarized in the tables above, point to the following key issues:

- If the proposed rates are implemented as is, across all provider categories, the overall budget impact is significant. For residential services, it would result in an increased budget of \$1,129,865, or 13.23 percent, of the current budget for that service group. The impact for substance abuse will also be similar (13.6 percent increase) although the total dollar impact will be smaller (\$355,366).
- There is significant variation in the impact of the proposed rates on the budget across service categories, ranging from a 21.9 percent decrease for residential transition housing services to a 64.5 percent increase in budget for substance abuse transition services. However, the overall impact to the OAPP budget is 13.3 percent.
- When assuming that no new funds will be available for these services in upcoming procurements, Mercer was able to arrive at a few options for adjusting the proposed rates to neutralize the budget impact. Two simple options are presented in the tables above. If either of these options or adjusted rate series were to be adopted, several key observations could be made:
 - If the service group adjusted rates were implemented, the movement of dollars and capacities would remain within the service group. Any gains or losses in available dollars would be offset within residential care services, and within substance abuse services. Within residential services there would be reductions in Hospice and Transitional housing which would offset increases in RCFCIs. Similarly, in substance abuse services, reductions in residential rehabilitation and residential detoxification would offset increases in transitional housing.

- If the line item adjusted rates were to be implemented, even as a transitional or "phase in" approach, the impact on providers would be minimized and unless entire service line items were discontinued, no offsets would transfer between service lines. In essence, this option would result in rates reverting to the current or close to the current rates and would not be reflective of the findings of this study.
- As an alternative to changing the proposed rates to maintain budget neutrality, OAPP may choose to implement the proposed rates by moving available funds between service categories or by altering the level of funded capacity for selected service categories. For example, the analysis indicated that Medi-Cal coverage for selected service categories does exist and the ability to transition all Medi-Cal-eligible patients to this source of funding will result in the availability of funds that can be used to cover other needed services.
- In the summary table presented above, impact on capacity as a result of the different rate options has also been presented. While it is important to understand the effects that rate set decisions have on the potential capacity for service as described by the measurement of available bed-days, capacity funding is not generally assumed in published rate systems. However, since the County of Los Angeles requires that all grant-funded contracts clearly specify a maximum contract allowable amount, OAPP could structure their contracts in such a way that limits to the funded capacity will allow the use of the proposed rates without any adjustments.

Mercer recognizes that beyond a certain level, a decrease in rates could be devastating to a provider and would jeopardize their financial health; it could even put them out of business. While it is expected that some of this impact will be mitigated through the appropriate access of funds available through other sources including Medi-Cal, Mercer also carefully evaluated the loss profile of the individual providers as part of this study and key decisions were made to mitigate unanticipated, adverse effects. For example, the recommended rate structure has been adjusted to the Budget Impact assuming that the general medical staff wage component of Direct Service Staff is used in most, but not all services. The Nurse Assistant (Attendant) staff level is assumed as part of the mix for residential emergency housing, and the exclusive staff category for residential transitional housing and substance abuse transitional housing. Additionally, the use of size/capacity-based adjustment factors has also been presented as an option that could be implemented, if necessary, to mitigate unanticipated effects of the rates on smaller providers.

Based upon the review of the Budget Impact and Provider Impact Analysis, OAPP has made a policy decision to seek to fund residential care and substance abuse services at the proposed rates based on service standards rather than at levels adjusted to maintain budget neutrality. Since no new funds will be available for these services in upcoming procurements, rate implementation will need to be associated with policy decisions relating to the movement of available funds between service categories, maximization of other sources of funding such as Medi-Cal and alterations in the level of funded capacity for selected service categories. The key policy decisions that OAPP is likely to make as it proceeds with the solicitation and procurement for residential and substance abuse treatment services, are presented in a subsequent section of this report.

5

THIRD-PARTY PAYER REIMBURSEMENT

In delivering any health or health-related service, the presence of multiple funding and payer sources inevitably results in high levels of complexity, both in terms of billing practices and reimbursement mechanisms. This is all the more true for publicly-funded systems such as the HIV/AIDS services that owe the majority of their budgets to funding sources of last resort. Typically, processing claims as a payer of last resort is a function described as Coordination of Benefits and relates to billing the appropriate entity responsible for payment. Coordinating payment from multiple funding sources including Medicare (Title XVIII), Medicaid (Title XIX), HRSA Ryan White CARE Act funds, the Substance Abuse Mental Health Services Administration, State and County funders, private-sector funding, or private insurance can be daunting when a client is eligible for more than one insurance or funding program. To better understand the complexities of multiple reimbursement mechanisms and to create a rate system that encourages the appropriate and optimal use of available funding sources, OAPP included an evaluation of third-party reimbursement as a key component of this rate study.

A knowledge of third-party reimbursement and an understanding of Coordination of Benefits is critical in a rate system that encourages optimal use of available funding sources.

Methodology

To address the issue of third-party reimbursement and to identify whether services for people living with HIV/AIDS are being reimbursed by other insurers or third-party payers, Mercer performed a series of investigatory activities that are summarized in the steps outlined below.

Mercer focused on a review of an array of services associated with people living with HIV/AIDS for the purpose of analyzing the status of Coordination of Benefits. Mercer also reviewed current processes for determining patient co-payments.

Step 1: Collect Information on OAPP Data Systems

Mercer obtained from OAPP staff existing information from the client information systems. The specific “screen prints” from the current OAPP prior-authorization and claims processing information systems that were collected and reviewed include:

- Client Basic Data,
- OAPP Report Demographics, and
- HRSA Client Level Information.

Step 2: Analyze Information System Elements and Reports

Upon receiving the screen prints, Mercer evaluated each one for evidence of three components of Coordination of Benefits among the funding sources:

- Indication that the person receiving services was eligible for coverage under one of the other funding programs, particularly at the time of eligibility for services, through OAPP.
- Identification of the agent that gathers the information for billing purposes and at what stage of assessment or services the information is gathered from the person receiving services. For example, was the information gathered by the provider at the time services were to be provided, at the time the referral was being considered by the provider, or was it gathered during an eligibility or intake review, or even later during services?
- Any evidence that the data field in which the information would be entered is a required field and whether it would be of the sort that might link to a claims processing or prior-authorization module that would be able to pend a claim or a prior-authorization as a result of the field being populated with the specific evidence of third-party coverage?

Step 3: Discuss Initial Observations with OAPP

After the initial review and analysis, Mercer met with OAPP and the Department of the Auditor-Controller staff to discuss preliminary findings and to seek clarification on certain issues related to third-party coverage. Through these discussions, many of Mercer's observations were confirmed.

Step 4: Review Public Sources of Funding

For the residential and substance abuse services included within this study, Mercer evaluated other public sources of funding available in the County of Los Angeles to determine if the services are covered by these public programs and if so, whether providers are maximizing these funds for the clients that they serve. In addition to a thorough analysis of Medi-Cal funding, Mercer also reviewed funding available through Housing Opportunities for Persons with AIDS (HOPWA), ADPA, RALF, and Los Angeles Department of Children and Family Services (DCFS). The methods used in completing this review and analysis included web-based research and interviews with representatives from the respective agencies.

An evaluation of public funding sources was performed to determine all funding sources for the selected services and whether providers are maximizing the use of these funds.

Step 5: Review Commercial Insurance Coverage

Another key area of focus for this rate study was the availability of commercial insurance coverage for the service categories included in this study. To address this, Mercer reviewed benefit packages of national and local commercial insurance providers and also interviewed experts in insurance benefit design to determine existing levels of coverage for these services.

Findings and Results

The observations made as a result of this analysis are presented in this part of the report under the following sub-sections:

- Third-party Coverage and Reimbursement,
- Coordination of Benefits, and
- Co-payments and Client Fees.

Third-Party Coverage and Reimbursement

For the residential and substance abuse services included within this rate study, Ryan White CARE Act funds obtained through HRSA must be considered funds of last resort. This is clearly mandated in the CARE Act of 2000 legislation. Outside this funding source, Mercer found that in the County of Los Angeles, a number of third-party funding programs currently exist and may be utilized to serve HIV/AIDS clients. Each of the key funding sources is discussed below and wherever possible, the amount of funding available from each source is also outlined.

Medi-Cal Program

Medi-Cal is the State of California's Title XIX Medicaid Entitlement Program and the largest source of publicly-funded care services in the State. Medi-Cal is governed by stringent and complex federal regulations, as well as California-specific rules to ensure optimal and appropriate use of public funds for health care delivery.

Complexity of Medi-Cal

The complexity of Medi-Cal is daunting to providers as well as clients, and is very often the root cause of unwillingness among providers to participate in the program. This was validated through the provider interviews conducted as part of this study where the common barriers to Medi-Cal participation as cited by providers included:

- limited awareness and knowledge of the processes associated with Medi-Cal,
- administrative complexity of the process of applying for and participating in Medi-Cal,
- perception of inadequacy of Medi-Cal rates for HIV services,
- fear of recoupment of Medi-Cal funding in an audit, and
- lack of the required claims processing and billing systems needed to successfully participate in Medi-Cal.

On the surface, obtaining Medi-Cal reimbursement may seem a fairly simple process linked to three main criteria:

- service must be a covered Medi-Cal benefit,
- client needs to be eligible and enrolled in Medi-Cal or the designated waiver, and
- provider must be certified to participate in Medi-Cal.

However, the more one delves into the program and its regulations, the more complicated and elaborate the system becomes. For providers, the complexity of Medi-Cal begins with the large

number of unique programs that exist under the Medi-Cal umbrella. Some of these programs are structured as traditional FFS reimbursement models while others are covered through managed care arrangements. States, such as California, have exercised the option made available through the Social Security Act to “waive” certain federal requirements and implement innovative health delivery programs through both program waivers [Section 1915(b) and (c)] and research and demonstration waivers [Section 1115]. Each of these waiver programs targets a specific population, has its own unique eligibility criteria, and often has distinct services covered within the program’s benefit package. Some of the programs that providers included within this study may be eligible to participate in include:

The complexity of Medi-Cal is a reflection of many issues including, multiple programs with different eligibility criteria and different application requirements for providers.

- Medi-Cal Model Nursing Facility (NF) Waiver,
- Medi-Cal NF Waiver,
- Residential Care Facilities for the Elderly (RCFE) Program,
- Medi-Cal Medical Case Management (MCM) Program,
- AIDS Medi-Cal Waiver Program (MCWP), and
- HIV/AIDS Expansion Waiver (projected implementation in 2005).

Adding to this complexity, each individual Medi-Cal program has its own provider application process. This process may also vary by provider category. Depending on the type of program, an application process may include:

- obtaining fire/safety clearances, and facility licensure,
- submission of a letter of intent and detailed application with supporting documentation,
- negotiations with DHS office of contracting,
- demonstration of utilization and quality monitoring processes and billing/claims submission systems, and
- on-site assessments and reviews of the provider facilities.

With these requirements, it is not surprising that smaller community-based providers are often extremely apprehensive about participating in the Medi-Cal program. Recognizing the complexity of Medi-Cal, California DHS provides fairly intensive training and technical assistance sessions for providers seeking to participate in Medi-Cal. The DHS provider relations website also provided value to current and prospective providers on a myriad of Medi-Cal related issues.

Medi-Cal Covered Services

Out of the residential service categories included within this rate study, only one service category is funded in its entirety by Medi-Cal and Medicare. While this category is labeled under the facility classification of CLHF, in the context of HIV/AIDS and based on licensure requirements, it is more aptly understood as Hospice care, although the two terms are not exactly interchangeable. To obtain a better understanding of the distinction between CLHF and Hospice, Mercer spoke with policy staff at DHS.

Based on the discussions with DHS and a review of California regulations, Mercer found that a CLHF is a residential home that provides skilled nursing care to persons with terminal or life-

threatening illness, or with catastrophic and severe injury (CLHF - Title 22 72201), which is Medi-Cal reimbursable. The CLHF funded by OAPP is also certified by DHS to provide Hospice service, which is also Medi-Cal reimbursable. Hospice services provide palliative care to persons who are terminally ill (Hospice Health and Safety Code 1267.13). From Mercer's review, it appears that the difference between the two services is that Hospice is limited to those with an expected life expectancy of six months or less, while CLHF could include patients with a longer life expectancy.

DHS also reports that it is the intent of the legislature to allow flexibility in the use of Hospice services and, for this reason, there is a process outlined by DHS that allows approval for payment of Hospice services to persons in residential settings. According to DHS, a provider can bill Medi-Cal for both CLHF and Hospice services when the services are provided by a Medi-Cal certified provider for a Medi-Cal-eligible person. Thus, there is potential for duplication of Medi-Cal funding for these services if the service recipient is Medi-Cal-eligible.

The current Medi-Cal rate for CLHF billed under the NF Level B (NF-B) rate is \$102.01 per diem. For Hospice, Medi-Cal has a number of rates covering a range of services. These rates are:

- **Residential Hospice** — \$140.46 per diem,
- **In-Home Hospice** — \$34.13 per hour,
- **Inpatient Respite** — \$147.62 per diem,
- **General Inpatient Hospice** — \$617.24 per diem, and
- **Continuous Care Hospice** (covers brief periods of crisis with a minimum of eight hours) — \$34.13 per hour.

As demonstrated in the nomenclature of each category, the difference in these services is primarily a reflection of the level of intensity of care and the venue of service delivery. With the changing profile of HIV/AIDS disease, the Medi-Cal category that is likely to reflect current service needs in most patients requiring Hospice services is that of residential Hospice. However, the current standards and regulations assume a more intensive type of care that resembles inpatient Hospice with medical supervision and 24-hour skilled nursing care. It must be noted that within the Hospice environment, both in California, as well as nationally, there is a significant movement from facility-based Hospice towards in-home Hospice service delivery. This is a reflection of both patient preferences, as well as the high cost of facility-based care.

Although an all-inclusive Medi-Cal residential rate is not available for residential providers other than in the Hospice category, specific service components may be Medi-Cal reimbursable. Some of these service components that are included in the Medi-Cal rate schedule include case conferences, psychological testing, health and mental evaluation/education, initial treatment planning, and case management. Case management is unique in that in most cases where it is reimbursable, it is associated with a specific MCWP.

For residential services other than Hospice, specific service components such as medical conferencing and psychological evaluations, may be Medi-Cal reimbursable.

For HIV/AIDS case management, the current reimbursement is under a "per member per month" (PMPM) rate of \$229.00 for a spectrum of services provided through the Primary Care Case

Management (PCCM) AIDS Waiver Program. Some of the services and their rate, as captured within the most recent Medi-Cal rate schedule, are presented in the table below.

Medi-Cal Rates for Residential Service Components		
Code	Procedure Description	Basic Rate
X4900	HEALTH AND MENTAL EVALUATION/EDUCATION	\$10.40
Z6700	IHMC CASE MANAGEMENT RN WORK — ONE HOUR VISITS	\$45.43
Z6750	NF- CASE MANAGEMENT — RN HOURLY	\$45.43
Z6780	MODEL CASE MANAGEMENT — RN -HOURLY	\$45.43
Z6914	CASE EVALUATION & INITIAL TREATMENT PLAN	\$30.13
Z5000	CASE MANAGEMENT — AIDS WAIVER	\$229.17
Z4310	MEDICAL CASE CONF, NURSE — PER 1/4 HOUR	\$8.40
Z4311	MEDICAL CASE, SOCIAL WORK — PER 1/4 HOUR	\$8.40
96100	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODI	\$41.79

Through discussions with senior staff at DHS, Mercer found that there is some ambiguity in the identification of HIV/AIDS services that are Medi-Cal reimbursable and that DHS is currently working to clearly identify HIV-specific services that would qualify for Medi-Cal reimbursement. This effort is of high priority to DHS, particularly due to the proposed implementation of the new HIV/AIDS Section 1115 Medi-Cal Waiver next year.

Some substance abuse services are covered under Medi-Cal, although coverage is fairly limited. The services covered under Medi-Cal and the rates of reimbursement for these services are listed in the table below.

Medi-Cal Rates for Substance Abuse Services			
Code	Description	Unit	Rate
ALCOHOL AND DRUG SERVICES (NON-PERINATAL)			
20, 21	NARCOTIC TREATMENT PROGRAM — METHADONE	DAILY	\$ 9.58
		MONTHLY	\$291.39
23, 24	NARCOTIC TREATMENT PROGRAM — LAAM	DOSE	\$ 22.61
		MONTHLY	\$293.93
26	NARCOTIC TREATMENT PROGRAM — INDIVIDUAL COUNSELING	10 MINUTES	\$ 14.05
27	NARCOTIC TREATMENT PROGRAM — GROUP COUNSELING	10 MINUTES	\$ 3.59

Code	Description	Unit	Rate
30 – 38	DAY CARE HABILITATIVE	VISIT	\$ 67.85
50 – 58	NALTREXONE	VISIT	\$ 21.19
80 – 83	OUTPATIENT DRUG FREE INDIVIDUAL COUNSELING	VISIT	\$ 70.25
85 – 88	OUTPATIENT DRUG FREE GROUP COUNSING	VISIT PER PERSON	\$32.33
ALCOHOL AND DRUG SERVICES (PERINATAL)			
20, 21	NARCOTIC TREATMENT PROGRAM — METHADONE	DAILY MONTHLY	\$ 10.76 \$327.28
26	NARCOTIC TREATMENT PROGRAM — INDIVIDUAL COUNSELING	10 MINUTES	\$ 21.22
27	NARCOTIC TREATMENT PROGRAM — GROUP COUNSELING	10 MINUTES	\$ 5.91
30 – 38	DAY CARE HABILITATIVE	VISIT	\$ 74.44
40 – 48	PERINATAL RESIDENTIAL	DAILY	\$ 76.18
80 – 83	OUTPATIENT DRUG FREE INDIVIDUAL COUNSELING	VISIT	\$106.08
85 – 88	OUTPATIENT DRUG FREE GROUP COUNSING	VISIT — PER PERSON	\$ 53.22

Despite limited Medi-Cal coverage for substance abuse services, the provider interviews revealed that many of the substance abuse providers are Medi-Cal certified and enroll eligible patients and bill Medi-Cal appropriately for covered services.

State and Federal Substance Abuse Funds

In addition to Medi-Cal funding, County of Los Angeles substance abuse treatment providers receive Substance Abuse Crime Prevention Act (Proposition 36) funds and Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. The California Department of Alcohol and Drug Programs administers both these funding sources to counties who in turn contract with and reimburse providers.

Proposition 36 was approved by California voters on November 7, 2000. The Act makes significant changes to state law, allowing certain non-violent adult offenders who use or possess illegal drugs to receive substance abuse treatment in lieu of incarceration. Eligible offenders receive up to one year of substance abuse treatment and six months of post-treatment aftercare. The Act appropriates \$120 million annually for counties to operate substance abuse treatment programs and to provide probation supervision.

The 2002 –2003 SAPT Block Grant amount for California was \$251,851,368. In addition, California providers received approximately \$36 million in discretionary grants, i.e., specialty grant programs that fund target populations. SAPT funding has several specific requirements for allowable funding, including a portion that targets individuals at-risk for or diagnosed as having HIV/AIDS.

These funding streams are available to all substance abuse treatment providers in the County of Los Angeles and should be actively and maximally utilized to provide quality services to patients with or without HIV/AIDS.

HOPWA Program

The City of Los Angeles serves as the administrator of the HOPWA Program for the entire geographical area of the County of Los Angeles. The Los Angeles Housing Department is the entity within the City designated to carry out the program. HOPWA is funded by the Federal Department of Housing and Urban Development (HUD) and covers a number of residential services. Some of the services currently supported by HOPWA and where potential duplication of funding may occur include:

- **Emergency Housing:** Providers of emergency housing and meal vouchers to HIV-infected persons and their families who are experiencing or will experience homelessness and who are referred by a participating referral agency.
- **Lease, Operating, and Supportive Services in Emergency and Transitional Housing:** Provides free and/or affordable short-term emergency and/or transitional housing and supportive services to homeless persons living with HIV/AIDS and their families.

HOPWA funds may be accessed by emergency and transitional housing providers through block grants. Despite attempts to contact the HOPWA program and obtain more specific details regarding grant awards, the information has not been forthcoming. It must be noted that in the past, there have been concerns around both the distribution of these funds and the oversight of the funds that are distributed.

Residential AIDS Licensed Facilities (RALF)

RALF is specialty state grant funding allocated by the California Department of Health annually through a formula methodology to all RCFCIs that submit a completed application for this grant. Statewide, \$1 million is available. Currently, funding for RALF services in the County of Los Angeles is as follows, although applications for the coming fiscal year are due later this winter:

RALF Funding for 2003		
Program	# Beds	Funding Amount
PALMS	25	\$89,310
PROJECT NEW HOPE	6	\$21,416
	5	\$17,843
SALVATION ARMY	25	\$89,310
SERRA	6	\$21,416
	12	\$42,856
BEING ALIVE LONG BEACH	10	\$35,710

Los Angeles County Department of Children and Family Services (DCFS)

DCFS provides a range of child welfare and child protective services, including GHs. While DCFS's goal is to find a family for each child, they fund GHs for children who have special needs or otherwise do not have access to a family home. Typically, children under the care and custody of DCFS are eligible for Medi-Cal and other State and Federal resources that support DCFS services. DCFS is the primary funding source for the GH funded by OAPP. All children serviced within this service category are eligible for Medi-Cal coverage. Currently, the DSS GH rate in the County of Los Angeles is \$5,613 per child per year.

Private Insurance

In general, private insurance plans for small and mid-market employer groups, exclude coverage for facilities that are not involved in the direct delivery of health care. For example, most contracts have a strict definition of a hospital. Programs set up to assist with activities of daily living will not meet the strict definition. Most contracts are designed to exclude non-hospital residential services. Some contracts provide for "partial hospitalization", but the terms and conditions strictly limit this coverage.

Group contracts provide coverage for "skilled NFs" which by definition provide "physical rehabilitation or medical services as long as that facility provides all the services necessary for medical treatment." But this definition mostly relates to nursing homes.

Most group plans provide coverage for RCFs outside a hospital setting as long as a person is immediately transferred to the facility following a hospital confinement of at least 24 hours. Without the transfer from confinement, no coverage is provided. Coverage admission, once granted, is generally time-limited.

Contractual provision related to medical necessity can be a "catchall" which gives the medical director of the health care organization some flexibility in approving "exceptional care" outside the normal definitions. However, this flexibility is rarely exercised.

Of the residential care services currently under study, the observations made regarding private insurance coverage are as follows:

- **RCFCI:** On the surface, these facilities may meet the definition of a skilled NF. If, however, the treatment is directed at support activities of daily living, most group plans would deny coverage since the "medical necessity" definition may not be satisfied.
- **ARF:** This type of facility does not meet any of the definitions of a covered facility. There have been cases, however, where a medical director has approved coverage for an ARF as a means of reducing the carrier's risk for inpatient confinement.
- **GH:** Like skilled NFs, this type of facility does not meet any of the definitions of a covered facility. There have been cases, however, where a medical director has approved coverage for a GH as a means of reducing the carrier's risk for inpatient confinement.
- **CLHF:** Hospice meets the definition of a skilled NF and is typically covered by most group plans.
- **Transitional Housing:** This type of facility does not meet any of the definitions of a covered facility.

With regard to substance abuse treatment services, private insurers will often pay for residential detoxification in a hospital setting. Detoxification in a “lesser” licensed facility is less common but still sometimes is provided. Methadone maintenance treatment is sometimes, but not regularly, covered. Other substance abuse treatment services in this study are generally not covered, although residential rehabilitation is sometimes covered but almost always time limited (30 days or less per year).

In summary, some private insurance companies may pay for residential care services, but it is really the exception rather than the norm. Most clients entering the public system do not have private insurance. Those that did have private coverage may have lost it when they lost their job due to their illness and inability to work. It must also be stressed that cost-shifting from the private to the public system does happen with regularity particularly for patients with chronic illnesses such as HIV/AIDS.

Coordination of Benefits (Third-Party Payment)

Coordination of Benefits is described as the function of identifying third-party coverage for services needed by a client and to bill these multiple third-party payers before accessing funds of last resort. This is often the responsibility of the provider of service and oversight and monitoring is provided by the funding agency. In many cases, a designated third-party administrator may also be used to assist in this process. As demonstrated through the preceding discussion, there are multiple funding-sources for residential and substance abuse services in the County of Los Angeles and the task of Coordination of Benefits across all these funding sources becomes all the more critical especially in the wake of increasing costs of care and flat or declining budgets for service delivery.

On examination of OAPP information system screen prints, Mercer found that there is a single question in the group of screen prints that, if filled in, would indicate whether or not the individual was covered for services by a third-party insurance plan. Mercer also found that third-party coverage information is supposed to be gathered by provider agencies at referral and periodically thereafter.

Mercer was able to confirm that while the data field in the current system is a required field for providers and that the information is sometimes gathered about third-party coverage, the submission of the data confirming third-party payment is not linked to any outside claims adjudicating system. Therefore, there is no process within OAPP to actually track whether the client has third-party coverage and if the provider submitted a third-party claim.

Utilization of third-party payer information in a client information file by cross-referencing the information in claims adjudication assures that a “cost avoidance” approach as opposed to a “pay and chase” approach is being taken. The cost avoidance approach is recommended by federal funding sources, such as Medicaid. However, linking the data field related to third-party payer to prior-authorization and claims adjudication systems that are apart from the systems containing third-party information, and particularly when used by agents other than the prior-authorization

and claims processing agencies (as is the case with OAPP), can involve major systems restructuring and be prohibitively expensive.

Due to the costs associated with the integration of systems to link third-party payer information to prior-authorization and claims adjudication data, Mercer recommends that the most efficient and cost-effective solution is to build on the processes already in place. Specifically, by ensuring that the data field for third-party payment is a required field and the information system links the field to the invoice from the provider, OAPP will have this information available for their back-end review and follow up. Through discussions with OAPP staff it was noted that currently OAPP does review fee determination and third party payer coverage as part of their on-going monitoring processes although the retrospective monitoring process is often time-consuming and complicated.

In practical terms, OAPP could employ one of two different options to accurately track third-party coverage information:

Option 1: OAPP could require that the providers submit an invoice that contains third-party payer information. When a client has third-party payer coverage, the invoice must be accompanied by an Explanation of Benefits from the insurer as evidence the insurer has been billed for covered services. OAPP then can reimburse providers only for the uncovered service up to the amount of the published rate.

The Health Insurance Portability and Privacy Act (HIPAA) contains certain clauses related to claims processing and Coordination of Benefits which though once were recommendations of the General Accounting Office, are now requirements under HIPAA. Clause § 162.1801 Coordination of Benefits Transactions and clause § 162.1802 Standards for Coordination of Benefits require that all electronic claims be submitted in ASC X 12N 837- Health Care Claim format – which includes any prior paid components of the claim. Towards this end, HIPAA Subprt P – Health Care Payment and Remittance Advice § 162.1601(b) Health Care Payment Remittance Advice Transaction requires the submittal of Explanation of (Medicare) Benefit (EOB, EOMB) documentation as part of claim submission, again in ASC X 12N 835 format.

This means that it is now required for publicly funded health and social services which are subject to HIPAA, that all claims be submitted after having been determined to be coverable by any third party, that such documentation be submitted with the claim in the proper format, and that only the unpaid (net) amount be claimed against the HIPAA compliant agency.

Option 2: A second option for OAPP could be the use of a Third-Party Administrator (TPA) or a similar external entity to work with the providers to provide confirmation of client eligibility prior to reimbursement and to verify that the primary insurer has been billed for covered services. This option may be a simpler alternative to implement given the complexity of current funding streams and should be explored further by OAPP.

The use of a Third-Party Administrator to confirm client eligibility and appropriate billing prior to reimbursement may be a viable option for OAPP.

Co-payment and Client Fees

Co-payment is a cost-sharing arrangement in which a person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. The service provider has responsibility for collection of the co-payment because insurance payments to the provider are made net the co-payment. However, in the case of Medi-Cal enrollees and Medi-Cal-funded services, it is not permissible for an agency to assess a co-payment from the person receiving services.

Providers interviewed in the first phase of this project universally reported that most of their clients were not assessed a co-payment. According to them, the administrative burden of collecting the co-payment and their liability if they refused services because the client did not have the co-payment combined to make the practice prohibitive.

Co-payment is probably not an avenue for significant additional revenue collection by OAPP.

Co-Payment is unlikely to be a significant opportunity for revenue collection for OAPP.

Hence, the residential service and substance abuse service rates that have been proposed as part of this study are designed to be net of any client fees or co-payments. Mercer has used the SSI assumptions to build the room and board costs into the rate structure. Through the analysis of provider cost reports, on average, the appropriateness of the SSI assumption for room and board expenses was verified.

However, it is also recognized that in some instances, this may be inadequate to cover all room and board-related expenses. If a provider seeks to recoup some of these expenses through the assessment of a client fee or co-payment, Mercer recommends that OAPP require the provider to submit and obtain approval of financial justification of a co-payment before implementation. OAPP should also develop a standard policy specifying the management of client fees. The Medicare program has established some guidelines relating to the management of client fees and may be referenced in establishing this policy. The guidelines are incorporated within various chapters of the Medicare Claims Processing Manual.⁶

It is important to note that based upon conversations with HRSA staff, Mercer found that HRSA does not have any specific recommendations on client fees and allows individual HIV/AIDS Agency discretion as to the structure and management of such an arrangement with appropriate disclosure.

⁶ www.cms.hhs.gov/manuals/104_claims

6

BARRIERS/DISINCENTIVES AND RECOMMENDATIONS

The best designed and most successful rate systems are those that are based on requirements for quality care within a category of service. Mercer has sought to adapt the rate architecture based on service descriptions developed based on a combination of current program requirements and recognized best practices. Throughout this process, Mercer identified barriers to the implementation of the proposed rate architecture that could potentially discourage or even prevent cost-effective, high quality service delivery. Specific attention was given to the following areas:

- restrictions on financial compensation methodologies,
- restrictions from outsourced labor and the collection of donations,
- any guiding regulations that may impede the ability of the County of Los Angeles to develop the provider network related to procurement,
- prohibitive regulation for management and establishment of sites,
- excessive restrictions and requirements that are not feasible in the County of Los Angeles, and
- community-based restrictions, such as availability of qualified staff that meet staff requirements.

Some of the key barriers identified through the course of this study are listed and discussed below. Wherever appropriate, Mercer has recommended strategies that OAPP could explore to address or alleviate these barriers or disincentives.

1. Medi-Cal Reimbursement

As discussed in the earlier chapter, Medi-Cal is a significant, albeit, a complex source of funding for HIV/AIDS services and it is critical that providers maximize the funding available through this entitlement program. Through this study, Mercer found that few providers are actively participating in the Medi-Cal program due to various barriers, both real and perceived. The key barriers expressed by providers were:

- limited provider awareness and knowledge of the processes associated with Medi-Cal,
- administrative complexity of the process of applying for and participating in Medi-Cal,
- perception of inadequacy of Medi-Cal rates for HIV services,
- fear of recoupment of Medi-Cal funding in an audit, and
- lack of the required claims processing and billing systems needed to successfully participate in Medi-Cal.

Faced with these barriers, many of the providers interviewed, particularly those providing residential services, have chosen not to participate in Medi-Cal. Mercer noted that currently there are no incentives for providers to bill Medi-Cal for many of the HIV/AIDS services that are covered benefits under Medi-Cal since providers obtain grants from OAPP for delivering these services. Mercer also noted that there is uncertainty, even at the State level, regarding HIV services that are or should be reimbursable, which is an additional barrier that needs to be addressed.

Mercer Recommendations: CARE Act of 2000 legislation mandates that the CARE Act be the payer of last resort, and HRSA has mandated that wherever other programs such as Medicaid exist for HIV/AIDS services, these funds should be maximized before using Ryan White funding. Based on these mandates, many states and jurisdictions require their HIV/AIDS providers actively participate in the Medicaid program. For the selected services in the County of Los Angeles, Mercer recommends the following:

- OAPP and the Commission should work closely with the DHS to identify and clearly define HIV/AIDS services that could be reimbursed by Medi-Cal and to identify the appropriate Medi-Cal programs/Waivers that HIV/AIDS providers may participate in.
- The collaboration with DHS could extend to the task of increasing awareness and knowledge among HIV/AIDS residential care providers of the importance and need for maximizing Medi-Cal funding for individual service components that are delivered. DHS provides training sessions to providers on various topics related to the Medi-Cal program. Providers should be encouraged to avail of these training opportunities.
- Since Medi-Cal reimbursement is only available to Medi-Cal certified providers, Mercer strongly urges all providers to seek Medi-Cal certification in the appropriate provider categories. OAPP may wish to consider stronger contractual language mandating demonstrated efforts by residential care providers to become eligible Medi-Cal providers and bill allowable Medi-Cal services.
- OAPP could use its established training curriculum to offer additional training and technical assistance to providers that are interested in pursuing Medi-Cal participation. This is an area that has been deemed a HRSA priority and Ryan White grant funds have been utilized in other states to offer this type of technical assistance. In the past, HRSA has provided third party payment training in the County of Los Angeles. Attendance at these types of training should be mandatory for providers that contract with the OAPP.

Stronger contract language encouraging providers to seek Medi-Cal certification is recommended.

2. Changing Staffing Needs based on Changing Disease Profile

Due to improved treatment technologies for people living with HIV/AIDS, the profile of “an AIDS patient” is changing. People are living longer and are less likely to present with late medical complications. Instead, people living with HIV/AIDS are more often presenting with behavioral health and psychosocial complications that require the services of staff with different expertise. These factors may necessitate a review of current regulations and modifications in some of the staffing requirements, particularly for some of the facilities intended to provide intensive medical care. For example, for RCFCI, the staffing requirements as per California

Code of Regulations are strongly focused on medical care and support services provided by nursing staff. The current requirements also mandate that case management in this setting is performed by nursing staff. Through the implementation of this rate study, OAPP has taken significant steps to recognize and address the change in staffing needs for clients in the rate development process. Based on the findings of this rate study, OAPP has chosen to develop rates that are based on staffing profiles with higher salary assumptions. The higher salaries result from the use of more qualified general health practitioners as compared to CNAs for certain care services. This has been performed with the intent to address the issue of changing service needs of patients and to allow providers the opportunity to hire appropriately qualified staff to provide new and more complicated services that may not be adequately managed through the use of CNAs.

In discussions with Community Care Licensure, Mercer also found that in the facilities providing non-clinically oriented housing services (transitional housing, emergency housing and ARF), there is no specific regulatory requirement for CNAs on staff for general care provision. However, for RCFCIs, in addition to the RNs, regulations list the need for CNAs or staff with documented evidence of equivalent experience or training.

Mercer Recommendations: Mercer recommends that OAPP explore the opportunity to review and revise some of the regulations based on the changing profile of people living with HIV/AIDS. Some of the potential changes that should be considered are:

- Instead of a nurse, a CNA or a medical social worker could perform general case management activities, such as the completion of risk assessments and evaluations.
- Staffing requirements should be expanded to include the use of psychologists, counselors, and other behavioral health professionals, as appropriate. For example, psychiatric technicians and certified substance abuse treatment counselors could substitute for some of the certified nursing assistant staff in the residential care programs.
- Since the new rates in many of the categories assume that services will be provided by health practitioners (psychiatric technicians, certified substance abuse treatment counselors, etc.) that are more qualified than CNAs to provide specialized care services, it is recommended that OAPP incorporate this requirement within the RFP for service providers, particularly in the residential care arena.
- If the flexibility in the regulations regarding the use of CNAs is changed, providers, especially in facilities providing non-clinically oriented services, will be able to hire other staff that will be able to meet the more pressing psychosocial needs of HIV/AIDS patients given the improvements in medical care.

3. Planned Bed Vacancy in Residential Care Services

A barrier that was noted by a number of residential care service providers that were interviewed was the payment issue related to bed vacancy. The bed may be vacant when the client takes an authorized vacation or planned absence from a program or when a client is temporarily transferred for another service (detoxification) but is still under the supervision and responsibility of the residential care provider.

Mercer Recommendations: In past work for other clients, Mercer has developed rates both with and without vacancy factors. A vacancy factor is a percentage add-on to published rates for unscheduled vacancies within a facility. The current proposed rates in the County of Los Angeles have been prepared without a vacancy factor because the issue in this environment is one of payment for absences, rather than vacancies. In most public funding environments, an absence (known patient who is gone for a number of days but is expected to return) is referred to as a “bed-hold” and is billable as a unit of service. Mercer recommends OAPP review the budget impact implications and reach a policy decision as to whether payments for bed-hold days will be included as part of provider contracts.

4. RCFCI Licensing Category Description

It was noted that the RCFCI, as described in the regulations, is extremely broad and includes provisions for a wide range of services, some of which may be covered under other service categories. One such service area is Hospice, which under the current regulations could be provided by a facility licensed as an RCFCI. Through its literature research and interviews with staff at the RCFCI, Mercer identified that the evolving nature of the AIDS epidemic has resulted in a shift in the focus of care at these types of facilities. Due to dramatic improvements in drug and therapeutic modalities, clients being serviced now are less likely to have severe medical needs and are more likely to require ongoing social, psychological, and other behavioral health services. The lack of specificity regarding the role and functions of this type of facility, coupled with the changing profile of HIV/AIDS clients, poses a challenge to the residential care service delivery.

Mercer Recommendations: To address these challenges, OAPP should work with these providers to define a clearer focus of care services. Since these facilities are best equipped to manage medically intense care needs, OAPP should explore the opportunity to modify the service description for RCFCI so that Hospice services could also be provided at these facilities or offer Residential Hospice as a discrete service. At the same time, the provider should seek to ensure that medically stable patients with only social support needs are appropriately referred to lower levels of care such as ARFs.

5. Duplication of Funding Sources - Hospice

Presently, OAPP funds one provider for residential services in a CLHF. As discussed earlier, both CLHF and Hospice are Medi-Cal and Medicare reimbursed services. Virtually all clients needing this service are eligible for Medi-Cal or Medicare and therefore OAPP funds a limited number of clients not covered by Medi-Cal or Medicare. In the context of HIV/AIDS services, the primary intended recipients of funding for this service category are those with terminal HIV/AIDS illness requiring Hospice care.

CLHF and Hospice are both Medi-Cal reimbursed services.

Through an evaluation of clinical standards, it was determined that with the changing profile of HIV/AIDS in the United States, the distinction between HIV/AIDS-specific Hospice and general Hospice is negligible. In recent years, the overall emphasis of Hospice services has also shifted

from care in a facility-based setting to a more community-based or home-based setting for care. It is also important to note that the success of the newer HIV/AIDS medications and treatment modalities has drastically reduced the need for end-stage Hospice care and many facilities that used to provide this service have either ended operations or have opted to expand into other areas of service delivery.

Mercer Recommendation: Since Hospice care in multiple care settings is a Medi-Cal covered service, Mercer recommends that OAPP meet with the current Hospice provider to discuss an aggressive strategy of maximizing Medi-Cal funding available for CLHF/Hospice care. The current regulations for HIV/AIDS CLHF assume that care should occur in an inpatient setting, which is the basis for a relatively high reimbursement rate for services. Currently CLHF services are funded by OAPP at a rate of \$425 per day. As required in the specification for this study, Mercer developed a service description and rate for CLHF. The resulting rate, \$414.26, reflects the clinical intensity of this service as “a residential home... that provides inpatient care...” (California Health and Safety Code, Section 1250-1263).

However, with the changing nature of the AIDS epidemic and improved treatment options, the need for inpatient or intensive 24-hour skilled nursing services for prolonged periods of time is declining. Simultaneously, the need for community-based or home-based Hospice services has increased.

Because of this trend, and the availability of alternative funding sources through Medi-Cal and Medicare, Mercer recommends OAPP consider discontinuing funding for CLHF services and provide Residential Hospice as an alternative service.

The Medi-Cal Hospice rate for residential Hospice is \$140.46 per diem and to ensure consistency in reimbursement across multiple programs, this rate may be used as the standard rate for Residential Hospice services for patients not eligible for Medi-Cal. Funding for a Residential Hospice service aligns with Ryan White CARE Act regulations that preclude using CARE Act funds for inpatient services.

6. Duplication of Funding Sources — GH for Children and Adolescents

OAPP currently has one contract for a GH. According to the contract, “HIV/AIDS GH services shall be provided to children, ages birth to 17 years diagnosed with HIV-disease or AIDS, including children whose diagnosis is indeterminate because of their age who: (1) are placed by DCFS and are in protective custody of the juvenile court; (2) are referred by community-based organizations; or (3) are placed voluntarily by families in crisis. In discussion with the GH provider, a representative indicated 50 percent of the children served have HIV/AIDS, the other 50 percent are siblings of children with HIV/AIDS or children with other medical conditions. The GH also serves infants who were exposed to HIV but have not yet been diagnosed.

The GH indicated that all the children served are referred through DCFS (but not necessarily through juvenile court) and covered by Medi-Cal. The DSS GH rate in Los Angeles County is \$5,613 per child per year. According to the provider, OAPP pays for “bed nights”, i.e., nursing

care coverage for 24 hours. It appears that OAPP funds supplement health care funds for children with HIV/AIDS provided by DCFS.

Mercer Recommendations: From provider interviews, it appears that all children served by the GH are Medi-Cal eligible and, therefore, Medi-Cal should be used to the maximum extent possible to provide services to these children. Because this service is part of the Department of Children and Family Services' continuum of care and the services are reimbursable through an alternative funding source (Medi-Cal), Mercer recommends that OAPP eliminate this service as part of its funded network in future procurement.

7. Duplication of Funding Sources — Methadone

Methadone is a covered Drug Medi-Cal service. Treatment for intravenous drug users is also a priority under the Substance Abuse Prevention and Treatment Block Grant. Funding from the Substance Abuse Crime Prevention Act is also a viable funding source to pay for methadone treatment.

Mercer Recommendations: Because funding for this service is provided from several funding sources, Mercer recommends that OAPP eliminate this service as part of its funded network in future procurement.

8. HRSA Reporting Requirements

For the delivery of the residential and substance abuse services within this study, the County of Los Angeles is governed by HRSA's reporting requirements related to Ryan White funding. Based upon interviews with HRSA staff, Mercer identified that these reporting requirements are contained in a series of reports produced at the beginning of the year — indicating the proposed and planned expenditures (in detail) and at the end of the year — indicating the actual expenditures paid. Currently, these reports are received by HRSA in satisfaction of its requirements. The establishment of estimated amounts at the beginning of the accounting period and the classification of these expenditures as an "encumbrance" against public funds is also required in Generally Accepted Governmental Accounting Standards.

HRSA requirements include an encumbrance in the beginning of each year and a year-end reconciliation of expenses at the end of the year, which can be built into the contracts when implementing the rates.

Mercer Recommendations: Mercer's recommendations as they relate to the implementation of the rate system while ensuring compliance with HRSA's reporting requirements fall into two areas, each described separately.

- **The Solicitation:** Since County of Los Angeles procurement codes specify that all contracts should have a maximum contract amount specified, OAPP will need to identify specifically, the maximum capacity and associated contract amount that will be funded for each service. While doing so, no guarantee of service utilization levels across the period of the entire year should be the subject of the solicitation or of the stated agreement in contract. Mercer recommends that the solicitation be prepared to solicit and contract for service units at stated fees, the service unit being one day of services received by an enrollee (in most cases) and the fee being the published rate for that service. Mercer further recommends that County

Counsel be involved in the plans for the solicitation in addition to whatever other current involvement.

- **Training:** Training is recommended for two groups, the County of Los Angeles staff and provider staff. The training for County of Los Angeles staff would include information related to the preparation of the solicitation, the management of payment systems in a fee for service environment, and the maintenance of current reporting requirements. It is important to note that no change is necessary in reporting requirements as they are currently occurring. The encumbrance reporting at the beginning of the year is still required and would not change, the expenditure reporting at the end of the year remains and would not change.

9. Housing and Homelessness

Regulations require the residential care facilities to discharge clients to appropriate housing, but providers in a number of residential care facilities voiced concern about clients who were homeless before entering their services, as well as the lack of affordable housing in general. According to the providers interviewed, there is a shortage of transitional housing options in the County of Los Angeles region and this posed a significant barrier in meeting the regulatory requirement of ensuring discharge to appropriate housing.

Mercer Recommendations: OAPP should explore options to increase the availability of transitional housing options in the County of Los Angeles region. An equitable rate will help in this regard, but additional incentives may also be required to encourage the establishment of more transitional housing facilities.

10. Availability of Trained and Qualified Service Staff

While the needs of clients have changed because of improvements in treatment technologies, the ability to hire appropriately trained and qualified staff to meet changing service needs is a challenge. OAPP is meeting this challenge with a contracted training provider to offer a variety of training sessions from “Harm Reduction Theory and Practice” to “HIV/AIDS: What Drug and Alcohol Staff Need to Know.” These trainings are an excellent opportunity for provider staff to develop or hone specific skills. During the provider interviews, several providers were complementary of the training opportunities while some providers requested an opportunity to provide input into the development of the training topics based on their experiences.

During interviews, most providers reported a high staff turnover rate, sometimes disrupting the course of treatment and intervention. This was stated as being a bigger concern than specific shortages in staffing. In Mercer’s experience, the service industries typically have a 20 percent turnover rate. When interviewing providers, we found that while turnover was cited as a significant problem, most providers had to research the turnover rate and described different methods for calculating turnover. Some providers reported virtually no turnover but others reported turnover rates significantly higher than the industry standard of 20 percent.

Mercer Recommendations: Mercer recognizes that hiring, training, and retaining qualified staff in the public health environment is a challenge. OAPP is actively involved in assisting providers

to address this challenge. Some additional recommendations that may be of value to the OAPP are as follows:

- To augment its current training efforts, OAPP may wish to involve its providers in discussions and reviews related to the comprehensiveness of its training activities and identification of opportunities for enhancements.
- High staff turnover in the public sector is an on-going and difficult issue to address. Therefore, Mercer recommends that OAPP include language in the contract that requires providers to measure turnover using a standard measure so turnover information can be collected and compared across providers. Understanding the scope and reasons for turnover will assist the providers in addressing the causes.

Once baseline data on turnover is available, it would be useful to have a provider forum on attraction and retention of staff and comparison of strategies that work to prevent turnover. In Mercer's experience, pay is not the only factor in attracting and retaining staff. Five areas drive employee commitment: (1) *Fit and belonging* — do employees like and get along with each other, and feel their interests are consistent with those of the organization? (2) *Status and identification* — do employees feel they are part of an organization that is special? (3) *Trust and reciprocity* — can the organization and its managers be counted on to do what is right and fair? (4) *Economic interdependence* — do employees believe they are receiving competitive pay and benefits? (5) *Emotional reward* — are employees satisfied with their job (career and development opportunities) and the quality of their work life? All these areas impact employee commitment and should be considered when identifying the drivers of turnover.

Case management has become a significant focus of attention and is required in many of the categories of services. However, the training programs available for case managers may need to focus more on specialty services, such as substance abuse and mental health counseling.

11. Rate System and Program-Related Training

In addition to the challenges of trained staff in the areas of service being reviewed, Mercer also

The implementation of the rate system will necessitate a comprehensive and aggressive training program for OAPP and provider staff.

recognizes that the implementation of the proposed FFS rate schedule will represent significant differences in the manner in which services to those in need will be conducted and reimbursed. These changes necessitate a comprehensive and aggressive effort to train both OAPP staff, as well as the providers on varying aspects of the rate system and disseminate appropriate information across all levels within provider organizations. In addition, training on other related issues such as the Medi-Cal program, Coordination of Benefits, and monitoring of service standards are critical for the successful implementation of the rates.

One of the most noteworthy changes related to the business operations related to these proposals is the shift to a "Cost Avoidance" platform of claims processing and adjudication away from "Pay and Chase." This is a HIPAA compliance issue that must be addressed. Currently there are components of a compliant system in place that could be brought to bear to ensure complete compliance. But the provider community is not currently operating under the burdens that compliance would introduce, and County staff may not be fully prepared.

Mercer Recommendations: As OAPP enters into a new contracting cycle with providers, they should consider using an outside entity to structure, propose, introduce and perform a full training program related to Claims Adjudication and Coordination of Benefits. This training should be given to County of Los Angeles staff and to provider agencies simultaneously so as to reinforce the fact that the necessity is generated at the authority of the Federal Government. It should encompass the concepts of prior-authorization, prior coverage determination, systems-requirements (ASC formats required by HIPAA), remit advice production and support, trouble shooting, and the rights and obligations for all the agencies involved that relate to HIPAA requirements, as well as those of the General Accounting Office, Single Audit OMB Circulars, and those related to the Cash Management Improvement Act (where they have influence). Specific training tools (training manuals, informational brochures and cheat sheets) may also be developed to reinforce the training on key components of the program and to ensure widespread dissemination.

12. Rising Costs of Workers' Compensation Premiums

The cost of workers' compensation premiums is not currently adequately covered with current contract funds and causes a burden to some providers.

Mercer Recommendation: High workers' compensation costs are a statewide issue. OAPP might want to quantify the scope of the problem, including cost and types of claims filed in order to assess potential options. Providers with high workers' compensation claims may need to initiate training in areas that result in worker injuries, such as lifting patients, or address physical barriers that may contribute to injury.

13. Limitation of Current Provider Contracts

Through the interviews, providers reported that current contracts do not allow the flexibility to expand or modify the contract based on changing circumstances, such as increases in workers' compensation premiums or other costs, or expansion goals of OAPP. Further, providers report there is little opportunity to address cost increases during contract negotiations due to the limited funding available to serve the population.

Mercer Recommendation: In future years, it may be necessary for OAPP to review the assumptions within the rate architecture and make adjustments within the contracting cycle for extraordinary costs in order to bring the rate system current to the prevailing costs within the environment.

14. Audit Coordination and Contractual Demands

For many residential care providers and for most substance abuse treatment providers, OAPP funding is not their primary source of funding. In fact, for these particular types of services, most are larger providers with many funding sources, each independently reviewing the provider for contract compliance. Providers identified a desire for joint auditing (and in some cases joint procurement) that could lessen their administrative burden and streamline contractual

requirements. During the interviews, substance abuse treatment providers urged OAPP to schedule a substance abuse treatment provider meeting to discuss contractual requirements and identify areas where administrative burden could be lessened.

Mercer Recommendation: Mercer understands that OAPP and the County of Los Angeles ADPA have different contractual requirements, different funding streams, and operate in environments that are subject to different levels of scrutiny and accountability. Given these differences, joint procurement and audits may not be feasible. However, greater collaboration between the agencies, with sharing of pertinent audit information/reports, could result in increased efficiency and effectiveness of audits for both agencies. Based on recommendations of some of the substance abuse treatment providers, it may be valuable for OAPP, ADPA, and providers to meet and collectively discuss opportunities for program enhancement and efficiency.

15. RFP Development and Contract Procurement

OAPP has significant policy decisions to make when developing the RFP for residential and substance abuse services. Most notably these policy decisions include:

- policy decision regarding service inclusion, especially CLHF and GH,
- policy decision regarding the continued funding of methadone treatment,
- policy decision regarding the use of three substance abuse residential rehabilitation rates based on intensity of services,
- policy decision regarding third-party liability and use of outside vendor,
- policy decision regarding implementation of scale/size differentials in the rates,
- policy decision regarding payment policy for bed-hold days for residential services,
- decision regarding the development of definitive written policies and procedures related to the new reimbursement methods, and
- policy decision on workers' compensation increase.

In addition, the RFP drives the way residential and substance abuse services will be delivered and funded for the next few years. Careful consideration should be given to every facet of the RFP.

▪ ***Mercer Recommendation:***

The RFP is the cornerstone upon which the residential and substance abuse service delivery system is built. Mercer recommends an inclusive process that consists of policy decision discussions and intensive OAPP internal meetings on areas identified in this report to evaluate intended and unintended consequences associated with the structure and content of the RFP. Of particular importance, is the decision around the continuum of care for residential care and substance abuse treatment services. Mercer recommends the elimination of CLHFs, GHs, and methadone treatment because other funding sources are appropriate for the provision of these services. Mercer recommends OAPP consider the following table as a guide for the type of service and reimbursement rate for funding a continuum of care to meet the current needs of its client population:

RESIDENTIAL CARE SERVICES							
	ARF	RCFCI	GH	CLHF + Hospice	Res. Hospice	Emerg. Housing	Trans. Housing
Current Rate Range	\$98.00 – \$125.00	\$113.00 – \$135.00	\$124.52	\$425.00	None	\$35.00	\$25.00 – \$44.00
Rate Developed for Study	\$129.34	\$147.59	\$130.38	\$414.26	None	\$42.80	\$28.32
Proposed Reimbursement Rate	\$129.34	\$147.59	None	None	\$140.46*	\$42.80	\$28.32

*Medi-Cal Reimbursement Rate

SUBSTANCE ABUSE TREATMENT SERVICES							
	Day Tx	Detox	Metha- done	Res. Rehab - Low	Res. Rehab - Medium	Res. Rehab - High	Trans. Housing
Current Rate Range	\$35.00	\$225.00	\$51.12		\$69.35 – \$112.00		\$18.00 – 24.20
Rate Developed for Study	\$43.76	\$239.21	\$50.32	\$58.11	\$82.18	\$112.27	\$ 40.27
Proposed Reimbursement Rate	\$43.76	\$239.21	None	\$58.11	\$82.18	\$112.27	\$40.27

16. City/County Coordination of Services including HOPWA

Through the course of this rate study, Mercer has recognized the complexity of funding for residential and substance abuse services in the County of Los Angeles where City, County and State agencies are involved in the management and financing of services. To maximize the limited resources that are available for services in the County and to ensure appropriate use of these funds, every effort must be taken to improve coordination between these various agencies. In a report published in December 2003, by the Mayor's AIDS Leadership Council⁷, it was stated that the City AIDS Coordinator's Office "would be able to better leverage its limited funds by improving coordination with the County. This is especially vital to the implementation of the recommendations in this section (on Addressing the Provision of Innovative and Evidence-Based HIV Prevention Programs.)" In the same report, the following is noted:

"Although it has a lower level of funding than the County, the City of Los Angeles is an integral player in the delivery of vital services for people living with HIV/AIDS or at high-risk for contracting this disease. While the County and the City each have a unique role, there is also substantial overlap. Currently there is no mechanism

⁷ White Paper, HIV and AIDS in Los Angeles: 21st Century Challenges and Approaches, Mayor's Leadership Council, December 2003.

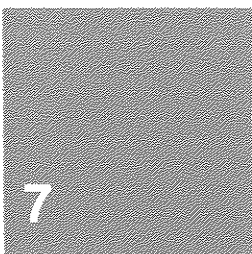
(formal or informal) for the coordination of services (care, treatment, housing, supportive or prevention) between the City of Los Angeles and the County of Los Angeles. This lack of coordination results in significant gaps in vital services desperately needed by people living with HIV/AIDS. It greatly increases the amount of work and the complexity of the work on the part of community-based organizations attempting to “piece together” funding from two different, but geographically overlapping, sources. The City and County have vastly different contractual and operating requirements, making it significantly more challenging for community based organizations to provide the best possible services for people living with HIV/AIDS. Finally, the current system is extraordinarily confusing and complicated for clients – they cannot understand why they must fill out multiple sets of conflicting paperwork to access services.”

The report recommends that HOPWA should work with the County of Los Angeles to develop mechanisms for coordination of housing and supportive services for people living with HIV/AIDS to “develop a formal process for ongoing communication and coordination between the HOPWA Coordinator and the City AIDS Coordinator and OAPP. Included in that process should be the coordination of strategic planning functions, to ensure that both funding sources are working together to develop the best possible service delivery model for people living with HIV/AIDS.

Another housing funding source to be coordinated is DHS funds for RCFCIs under the RALF. Through a request for application process, five County of Los Angeles RCFCIs currently receive funding ranging from \$17, 843 for a five-bed facility to \$89,310 for a 25-bed facility.

Mercer Recommendation: Mercer recommends that OAPP initiate immediate discussions with the City AIDS Coordinator’s Office about their intent to release an RFP for residential services and identify strategies to maximize funding, especially coordinated HOPWA services.

In addition, the RFP should specifically request information about other funding sources such as RALF (for RCFCIs) and ADPA funding (for substance abuse services) and ask providers to be specific regarding how OAPP funding will be used.



NEXT STEPS

Through this study, an actuarially-sound and locally relevant rate system has been proposed that supports clinically-appropriate residential care and substance abuse treatment services for people living with HIV/AIDS in the County of Los Angeles. A critical next step in the implementation of the rates is the finalization of policy and process decisions related to the level of budget funding available for these services. This will also involve policy decisions regarding the level of impact that OAPP will allow individual providers to sustain as a result of the new rates. Adjustments to the rates can easily be made based on these policy decisions.

It is commendable that throughout the study, OAPP has demonstrated a strong commitment to ensuring a collaborative process in rate development. To that end, OAPP and Mercer met with residential care and substance abuse treatment providers in August 2003, to provide an overview of the rate architecture. Additionally, providers were interviewed as part of this study to obtain information regarding their programs and to understand their greatest challenges in providing high quality, cost-effective services.

To facilitate the successful implementation of this proposed rate architecture, this level of County and provider collaboration should be continued and strengthened. OAPP envisions the following next steps in this regard:

- review of the findings and recommendations, as well as the actual rates with the Commission on HIV/AIDS Health Services,
- release of the study report for public comment and review,
- release of an RFP for residential care and substance abuse treatment services, and
- program implementation based upon the new rate architecture.

The steps and the timeline established by OAPP for these activities are presented in the following table.

SUMMARY OF NEXT STEPS	
Task	Tentative Date
Residential Care and Substance Abuse Treatment Services Rate Study – Final Report	February 2004
Review Report and Rate with Commission on HIV/AIDS Health Services	February 2004
Public Comment and Review	February 2004
Release RFP	August 2004
Service Implementation	March 2005

In any rate development exercise, the initial hurdles and barriers that may be encountered are numerous. This is clearly demonstrated in the list of barriers that were identified through the course of this rate study and that are presented in this report. While Mercer has sought to present recommendations and potential solutions that address or mitigate these barriers, it is clearly understood that given competing priorities and limited resources, a phased approach will need to be employed in the implementation of these recommendations. Some recommendations deserve immediate attention while others should be addressed in and through the RFP process. Other issues may require a more sustained and long-term approach and can be addressed after the release of the RFP. A summary of the recommendations categorized according to the timeframe of implementation are presented in the table below. The recommended allotment of time for each of these listed actions is based on Mercer's previous experience in the development, construction, and management of a full-scale solicitation for the implementation of published rates.

Implementation Phase	Agencies Involved	Recommended Actions	Recommended Timeframe
Public Comment and Review	Commission on HIV/AIDS Health Services; Providers; Other Agencies (DCFS, Mayor's AIDS Leadership Council)	<ul style="list-style-type: none"> Seek input from stakeholders. 	February 2004
Contract Development	OAPP	<ul style="list-style-type: none"> Identify specific opportunities for flexibility in contract language to make mid-contract changes at the discretion of OAPP. Specify mechanisms for invoicing and billing as services are rendered. Establish requirements for collection of performance measures, staff turnover, and other data. 	March 2004

Implementation Phase	Agencies Involved	Recommended Actions	Recommended Timeframe
RFP Development	OAPP	<ul style="list-style-type: none"> Establish requirements for encumbrance and reporting to meet HRSA requirements. Develop (draft) contract documentation. Policy decision on rates based on budget impact. Policy decision on vacancy rate for residential services. Policy decision on service inclusion, especially for those services currently covered by Medi-Cal. Policy decision on TPL and use of outside vendor; develop definitive written policy. Policy decision on worker compensation increase. Review this report for inclusion of mandatory requirements, for example staffing level expectations. Establish RFP review criteria. 	March 2004
RFP Release	OAPP	<ul style="list-style-type: none"> Finalize contract format and language. Solicitation review and approval. Formal Release of RFP for Residential and substance abuse Services. Hold bidder's conference. 	April – June 2004
RFP Review	OAPP	<ul style="list-style-type: none"> Select expert panel to serve as reviewers. Use standard scoring guide for review. Hold bidder's meetings if necessary. Schedule time frame for non-responsive bids to be resubmitted. 	September 2004
Preparation for Contract Award	OAPP	<ul style="list-style-type: none"> Finalize any and all changes to contract documentation. Complete Scoring and use of selection criteria, perform external review of scoring and selection practices. Notify bidders of award (If "Best and Final" provisions are offered they should be completed at this point – note this would not be available in reference to rates or financial criteria). 	October 2004 – January 2005
Training and Information	OAPP	<ul style="list-style-type: none"> Mandatory Medi-Cal Training for OAPP staff and providers. Work with CCL and DHS on requested licensure changes, especially those related to staffing and on RCFCI as a Hospice provider. Work with City AIDS Coordinator Office on HOPWA funded services for residential discharges. Review training curriculum for comprehensiveness; identify new training areas. Develop training on performance indicator requirements, data collection and audit review. 	February 2004 – March 2005
Service Implementation	OAPP	<ul style="list-style-type: none"> Contract execution. Contract monitoring. 	March 2005

Mercer is privileged to have had the opportunity to work with OAPP and the County of Los Angeles on this exciting and innovative rate study. Based upon Mercer's experiences in the areas of HIV/AIDS and rate development across the United States, it is clear that the County of Los Angeles is a leader in the effort to link HIV/AIDS reimbursement to appropriate clinical standards and practices, thereby ensuring both high quality and cost-effective service delivery. Mercer is confident that through the collaboration of the County and its HIV/AIDS providers, a planned and coordinated implementation strategy, and appropriate training for all those involved, OAPP will be able to successfully implement this rate architecture and thereby serve as a model for structured and equitable reimbursement methodologies for other HIV/AIDS programs nation-wide.

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APPENDIX A

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PERFORMANCE INDICATOR SUMMARY

HIV/AIDS Indicator Evaluation for Residential Services and Substance Abuse Treatment Funded by the County of Los Angeles, Office of AIDS Programs and Policy

The following table lists performance indicators for residential services and substance abuse treatment funded by the County of Los Angeles, Office of AIDS Programs and Policy (OAPP). The indicators for each service group are listed in two parts: Part I, which includes indicators currently identified in the Service Descriptions and Part II, which includes other indicators of relevance that might be considered for implementation later. Part I indicators were identified by OAPP staff as priority indicators that addressed issues of **satisfaction, access, or effectiveness**.

The table also identifies the source of data to measure the indicator, the applicable service category, and a value ranking, which includes:

- **High:** Relatively easy to measure based on current data collection methods and/or is a critical measure of the quality of services;
- **Medium:** More difficult to measure and/or has a less clearer relationship with quality of services, as prescribed by standards; and
- **Low:** Most difficult to measure and/or has an ambiguous relationship with quality of services, as prescribed by standards.

The “rationale” column provides brief comments on specific issues for consideration.

To promote system-wide comparison and development of benchmarks, Mercer Government Human Services Consulting (Mercer) recommends collecting similar data on performance from all providers. Mercer recognizes that different services may require specialized performance indicators but, typically, a core set of indicators can be created that can be collected from all the providers. Presently, OAPP’s contract language may be slightly different for various services, but many of the indicators collect similar data. In the following table, Mercer edited the language of the indicators to emphasize the key elements being measured. The table highlights where similar performance indicators are in use. Mercer recommends that future enhancements to performance indicators emphasize measuring consistent standards across providers.

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PERFORMANCE INDICATOR SUMMARY

RESIDENTIAL SERVICES PERFORMANCE INDICATORS					
ARF – Adult Residential Facility	GH – Group Home RCFCI – Residential Care Facility for the Chronically Ill TH – Transitional Housing				
CLF – Congregate Living Facility					
EH – Emergency Housing					
Performance Measure	Data Source	Applicable Service Category	Indicator Value/Validity	Rationale/Comments	
Priority Indicators Currently in Service Descriptions					
1	Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Service Plan (INSP). (Goal – 100%) PRIORITY - ACCESS	Medical Record	ARF, CLF, RCFCI, GH, TH, EH	High	OAPP requirement and critical component of good care practices.
2	Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%) PRIORITY – ACCESS	Medical Record	ARF, CLF, RCFCI, GH, TH, EH	High	OAPP requirement for GH only; common indicator across multiple categories; regular medical care for HIV+ clients is a key component of high quality care.

* Indicator Value/Validity is based upon the ease of indicator calculation and the validity of the indicator as a measure of quality services.

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PERFORMANCE INDICATOR SUMMARY

RESIDENTIAL SERVICES PERFORMANCE INDICATORS						
ARF – Adult Residential Facility CLF – Congregate Living Facility EH – Emergency Housing		GH – Group Home RCFCI – Residential Care Facility for the Chronically Ill TH – Transitional Housing				
Performance Measure			Data Source	Applicable Service Category	Indicator Value/ Validity	Rationale/Comments
3	Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%) PRIORITY - SATISFACTION		Client Satisfaction Survey	ARF, CLF, RCFCI, GH, TH, EH	High	Common indicator across multiple categories; most providers already perform satisfaction surveys.
4	Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%) PRIORITY - ACCESS		Medical Record	ARF, CLF, RCFCI, GH, TH, EH	High	OAPP requirement; important indicator for emergency and transitional services where time constraints may preclude development of a formal INSP.
5	Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and transmission-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%) PRIORITY - EFFECTIVENESS		Client Satisfaction Survey	ARF, CLF, RCFCI, GH, TH, EH	High	An important area of quality services that is often omitted in residential care settings; most providers perform surveys which can be modified to obtain this information.

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PERFORMANCE INDICATOR SUMMARY

RESIDENTIAL SERVICES PERFORMANCE INDICATORS							
ARF – Adult Residential Facility		GH – Group Home RCFCI – Residential Care Facility for the Chronically Ill TH – Transitional Housing	Performance Measure	Data Source	Applicable Service Category	Indicator Value/ Validity	Rationale/Comments
CLF – Congregate Living Facility							
EH – Emergency Housing							
Other Indicators Considered							
6	Establish baseline and perform on-going monitoring of the percent of clients with active HIV/AIDS case management services. (Goal – 80%) PRIORITY - ACCESS		Medical Record	EH, TH (Could be standardized across multiple service categories.)	High	OAPP requirement; common requirement of standards in multiple residential service categories; case management for HIV clients is a critical and standard component of good care.	
7	Establish baseline and perform on-going monitoring of the percent of clients that report nursing intervention with pain control measures within 15 minutes of the client's request for medication/relief. (Goal – 85%) PRIORITY – TIMELINESS OF CARE		Medical Record	CLF	High	Providers may have to modify existing survey to collect this data.	

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PERFORMANCE INDICATOR SUMMARY

RESIDENTIAL SERVICES PERFORMANCE INDICATORS				
ARF – Adult Residential Facility CLF – Congregate Living Facility EH – Emergency Housing	GH – Group Home RCFCI – Residential Care Facility for the Chronically Ill TH – Transitional Housing			
	Performance Measure	Data Source	Applicable Service Category	Indicator Value/ Validity
	8 Establish baseline and perform on-going monitoring of the percent of clients having a monthly case conference to review their status. (Goal – 80%) PRIORITY – APPROPRIATENESS OF CARE	Medical Record	ARF, RCFCI	Moderate
				OAPP requirement yet difficult to quantify the need for a monthly conference in all cases.

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PERFORMANCE INDICATOR SUMMARY

SUBSTANCE ABUSE PERFORMANCE INDICATORS					
DT – Substance Abuse Day Treatment MM – Substance Abuse Methadone Maintenance RD – Substance Abuse Residential Detoxification		RR – Substance Abuse Residential Rehabilitation SATH – Substance Abuse Transitional Housing			
Performance Measure		Data Source	Applicable Service Category	Indicator Value/Validity	Rationale/Comments
Priority Indicators Currently in Service Descriptions					
1	Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Service Plan (INSP). (Goal – 100%) PRIORITY - ACCESS	Medical Record	DT, MM, RD, RR, SATH	High	OAPP requirement and critical component of good care practices.
2	Establish baseline and perform ongoing monitoring of the percent of clients who have had at least one medical care consultation during the substance abuse treatment episode. PRIORITY – ACCESS	Medical Record	DT, MM, RD, RR, SATH	High	OAPP requirement for GH only; common indicator across multiple categories; regular medical care for HIV+ clients is a key component of high quality care.

* Indicator Value/Validity is based upon the ease of indicator calculation and the validity of the indicator as a measure of quality services.

APPENDIX A

PERFORMANCE INDICATOR SUMMARY

SUBSTANCE ABUSE PERFORMANCE INDICATORS					
DT – Substance Abuse Day Treatment		RR – Substance Abuse Residential Rehabilitation			
MM – Substance Abuse Methadone Maintenance		SATH – Substance Abuse Transitional Housing			
RD – Substance Abuse Residential Detoxification					
Performance Measure		Data Source	Applicable Service Category	Indicator Value/ Validity	Rationale/Comments
3	<p>Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with the services received through the program. (Goal – 90%)</p> <p>PRIORITY - SATISFACTION</p>	Client Satisfaction Survey	DT, MM, RD, RR, SATH	High	Common indicator across multiple categories; most providers already perform satisfaction surveys.
4	<p>Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%)</p> <p>PRIORITY - ACCESS</p>	Medical Record	DT, MM, RD, RR, SATH	High	OAPP requirement; important indicator for emergency and transitional services where time constraints may preclude development of a formal INSP.
5	<p>Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)</p> <p>PRIORITY – EFFECTIVENESS</p>	Client Satisfaction Survey	DT, MM, RD, RR, SATH	High	An important area of quality services that is often omitted in residential care settings; most providers perform surveys which can be modified to obtain this information.

APPENDIX A

PERFORMANCE INDICATOR SUMMARY

SUBSTANCE ABUSE PERFORMANCE INDICATORS					
DT – Substance Abuse Day Treatment		RR – Substance Abuse Residential Rehabilitation			
MM – Substance Abuse Methadone Maintenance		SATH – Substance Abuse Transitional Housing			
RD – Substance Abuse Residential Detoxification					
Performance Measure		Data Source	Applicable Service Category	Indicator Value/ Validity	Rationale/Comments
Other Indicators Considered					
6	Establish baseline and perform ongoing monitoring of the percent of clients who have an identified HIV/AIDS case manager at discharge. PRIORITY – CONTINUITY OF CARE	Medical Record	DT, MM, RR, SATH	High	OAPP-recommended criteria; case management for HIV clients is a critical and standard component of good care.
7	Establish baseline and perform ongoing monitoring of the percent of clients enrolled in RD (self-help groups, other support groups, or licensed or certified substance abuse treatment programs) after discharge from the RD program. PRIORITY – CONTINUITY OF CARE	Medical Record	RD	High	Important for RD programs to link clients with continued services, otherwise clients “cycle through” multiple detox episodes; during active alcohol and drug use, judgment may be impaired endangering the individual and others.

APPENDIX A

PERFORMANCE INDICATOR SUMMARY

SUBSTANCE ABUSE PERFORMANCE INDICATORS						
DT – Substance Abuse Day Treatment	RR – Substance Abuse Residential Rehabilitation		Rationale/Comments			
MM – Substance Abuse Methadone Maintenance	SATH – Substance Abuse Transitional Housing					
RD – Substance Abuse Residential Detoxification						
Performance Measure			Data Source	Applicable Service Category	Indicator Value/ Validity	
8	Establish baseline and perform ongoing monitoring of the percent of clients who are illicit drug-free at time of discharge, as evidenced by the last toxicology screening. PRIORITY – EFFECTIVENESS OF CARE		Medical Record	DT, MM, RR, SATH	High	Frequently collected information; objective; important to funders; indicator of successful outcome of treatment.
9	Establish baseline and perform ongoing monitoring of the percent of clients who have not had an arrest during the DT episode. PRIORITY – EFFICIENCY OF CARE		Medical Record	DT, MM, RR, SATH	High	Frequently collected information; shows cost off-set to other systems; important to funders; indicator of successful outcome of treatment.

APPENDIX B

APPENDIX B

LIST OF PROVIDERS INTERVIEWED

Contact Person Interviewed	Organization	Type of Provider	Date Interviewed
<i>Substance Abuse Providers</i>			
Vivian Brown	Prototypes	Substance Abuse Residential Rehabilitation	10/23/03
Lynne Appel	Southern California Alcohol and Drug Program	Substance Abuse Transitional	10/27/03
Robert Nelson	Substance Abuse Foundation of Long Beach	Substance Abuse Day Treatment, Substance Abuse Residential Rehabilitation, and Substance Abuse Transitional	10/27/03
Kathleen Watt	Van Ness	Substance Abuse Residential Rehabilitation, and Substance Abuse Day Treatment	10/28/03
Albert Sarnella Stan Galpertson Joe Morse Stewart Barney Sylvia Denala	Tarzana	Substance Abuse Residential Rehabilitation, Substance Abuse Detoxification, and Substance Abuse Transitional	10/28/03 and 11/04/03
Bill Wilson	Western Pacific Rehabilitation	Substance Abuse Methadone Maintenance	10/30/03
Terry Cannon Andy Worrel	Behavioral Health Services	Substance Abuse Residential Detoxification and Substance Abuse Residential Rehabilitation	11/03/03
<i>Residential Providers</i>			
John King, Dr. Levine, Richard Caines, Kyle Baldwin	Weingart Center	Transitional Housing and Emergency Housing	10/23/03
Jeffrey Lane	Salvation Army, Allegria	Residential Care Facility for the Chronically Ill	10/27/03
Kevin Pickett	Palms	Residential Care Facility for the Chronically Ill	10/28/03
Bridget Tweddell	Project New Hope	Adult Residential Facility and Residential Care Facility for the Chronically Ill	10/29/03
Dyke Ouderkirk	AIDS Health Care Foundation	Congregate Living Health Facility	10/29/03

Contact Person Interviewed	Organization	Type of Provider	Date Interviewed
Joel Roberts	PATH	Transitional and Emergency Housing	10/29/03
Jackie Gelfand	Caring for Families and Children with AIDS	Group Home	10/30/03
Peratta Tolbert	Santa Maria and St. Joseph Houses	Residential Care Facility for the Chronically Ill	10/30/03
David Grumwald	LA Family Housing Corporation	Transition Housing	11/4/03
Whitney Engeram	St. Francis House	Transitional Housing and Residential Care Facility for the Chronically Ill	11/4/03
Rosetta Chamberlain	JE Abernathy Community Outreach	Adult Residential Facility	11/5/03
Terry Soldano Raul Pavia	Serra	Residential Care Facility for the Chronically Ill	11/6/03

APPENDIX C



**COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health**

THOMAS L. GARTHWAITE, M.D.
Director of Health Services and Chief Medical Officer

JONATHAN E. FIELDING, M.D., M.P.H.
Director of Public Health and Health Officer

Office of AIDS Programs and Policy

CHARLES L. HENRY, Director
600 South Commonwealth Avenue, 6th Floor
Los Angeles, California 90005
TEL (213) 351-8000 • FAX (213) 387-0912

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October 14, 2003

Executive Director
Residential Service Provider
Substance Abuse Service Provider

Dear Service Provider:

As you know, the Department of Health Services Office of AIDS Programs and Policy (OAPP), in consultation with the Los Angeles County Department of Auditor-Controller, has commissioned Mercer Human Resource Consulting (Mercer) to conduct an HIV/AIDS Residential and Substance Abuse Services Special Rate Study.

The main focus of the study is to develop an actuarially sound and clinically valid methodology for determining fee-for-service (FFS) reimbursement rates for HIV/AIDS residential and substance abuse services based on appropriate clinical practices and established standards of care. OAPP has been working with Mercer to provide contractual and financial information about programs currently funded and, on Friday, August 28, 2003, hosted meetings with all residential and substance abuse providers to discuss Mercer's proposed methodology.

During the meetings, Mercer discussed the need to interview individual providers to learn more about programs and to obtain information that is pertinent to the study. To facilitate the interview process, Mercer has developed the enclosed interview guide, focusing on services, practices, staffing and funding. In preparation for the interview, we ask that you review and complete the guide in consultation with your Program Director, Clinical Director and Finance Director.

Within the next few days, Mercer will contact you to arrange time during the week of October 20, 2003 to interview you, via telephone. We recommend that all individuals who contribute to the completion of the guide participate in the interview so that the guide may be finalized. The interview should take approximately 30 minutes. Submission of the guide prior

Service Provider
October 14, 2003
Page 2

to the interview is not required.

If you have any questions or need additional information, please contact Patricia Gibson, Director of Financial Services, at (213) 351-8111.

I thank you in advance for the time that you and your staff invest in this very important study.

Very truly yours,

Charles L. Henry, Director
Office of AIDS Programs and Policy

CLH:pg
RateInterview

Enclosure

c: Service Provider Program Director
 Service Provider Fiscal Director
 John F. Schunhoff, DHS
 Patricia Gibson, OAPP
 Diana Vasquez, OAPP
 Brian Henricks, Department of Auditor-Controller
 Terri Goens, Mercer
 Chron (CLH)

October 14, 2003

Provider Interview Guide

County of Los Angeles
Department of Health Services
Office of AIDS Programs and Policy

MERCER

Government Human Services Consulting

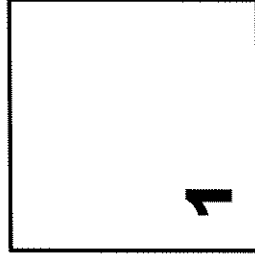


Marsh & McLennan Companies

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2. General Company/Organization Information2



Purpose of Interview

The County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy (OAPP) engaged Mercer Government Human Services Consulting (Mercer) to conduct a Residential and Substance Abuse Services Special Rate Study. Both OAPP and Mercer want the study to engender a collaborative process with Residential and Substance Abuse Services providers. We created this interview guide to provide an efficient process for gathering up-to-date information about your organization's services and staffing. Our goal for the interview is to obtain information about your organization for input to the Los Angeles County Rate Setting process. If you have questions about the Rate Study or Mercer's role, please feel free to contact:

Patricia Gibson, Director, Financial Services Division
Office of AIDS Programs and Policy
600 S. Commonwealth, 6th Floor
Los Angeles, CA 90005
213 351 8111

The interview will focus on services, practices, staffing, and funding and should take approximately 30 minutes. We may have follow-up questions once the interview is complete and may request additional information in writing. Thank you for your participation and your input into the rate setting process.

General Company/Organization Information

This part of the interview focuses on general information about your organization, including types of services provided, funding sources, senior staff positions, and types of positions your organization hires.

Name of Company:

Administrative Office:

Street Address:

City:

Zip Code:

Phone:

Fax:

Website:

Non-Profit:

Profit:

Contact for RFI Responses:

Name and Title:

Direct Phone:

Mobile Phone:

Fax:

Email:

Provider Interview Guide

County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy

1. Is your organization certified to provide Medi-Cal services?

☐ Yes ☐ No

Medicare?

☐ Yes ☐ No

Does your organization bill other third-party insurers? ☐ Yes ☐ No

If yes, please specify:

2. How many years has your organization been providing services to persons with HIV/AIDS?

3. How many clients/residents do you currently serve? Provide a total count of clients by service site.

Provider Interview Guide

County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy

4. What percentage of clients/residents have:

HIV/AIDS:

Substance Abuse Issues:

Both HIV/AIDS and Substance Abuse Issues:

5. Does your organization provide services to other populations?

☐ Yes

☐ No

If yes, please describe.

6. Service Type, Capacity, and Funding: Which of the following services does your agency provide? What is the service capacity? Funding Source? (If there are multiple sites for the same service, please provide information on specific sites.)

Service	Capacity	Primary Funding Source	Other Funding Sources (Specify)	Licensed?
Adult Residential Facility				
Congregate Living Health Facility				
Transitional Housing				
Emergency Housing				
Group Home/Specialized – Children				
Residential Care Facility for the Chronically Ill				
Transitional Housing – Substance Abuse				
Residential Detoxification				
Residential Rehabilitation				
Substance Abuse Transitional Housing				

Provider Interview Guide

County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy

Service	Capacity	Primary Funding Source	Other Funding Sources (Specify)	Licensed?
Outpatient Day Treatment				
Outpatient Methadone Maintenance				
Outpatient Methadone Detoxification				

7. How many employees do you currently have?

Full time:

Part-time:

Contracted:

8. What is your staff turnover rate?

Direct care staff turnover rate?

9. **Titles and Responsibilities.** Provide the job titles/positions (e.g., residential counselor, facility manager, director of nursing) of your organization; describe the basic job requirements (e.g., education and experience), and the position responsibilities (e.g., treatments, care and supervision of residents, intake and assessment, recreation, needs and services planning, referral and linkages, client and family education).

Personnel/Job Titles and Responsibilities

JOB TITLE OR CATEGORY	BASIC REQUIREMENTS	BRIEF DESCRIPTION OF RESPONSIBILITIES

Provider Interview Guide

County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy

- 10. For each type of residential (not substance abuse) service your organization provides, please provide the direct care staffing ratios (e.g., 1:10).** Please describe differences between day (7:00 a.m. to 10:00 p.m.) and night (10:00 p.m. to 7:00 a.m.) staffing levels. Direct care staff is defined as staff that provides 90 percent of their time performing direct care activities with the clients. If you have multiple sites with different staff ratios, please provide information for each site.

Residential Service Direct Care Staff to Client Ratio

RESIDENTIAL	RN*	LPN*	Nurse Practitioner	MD	Physician Assistant	OT	OT Assistant	Physical Therapist	PT Assistant	Pharmacist	Personal Care Attend.*	Residential Counselor*	Social Worker	Psychologist	Activities Coordinator*	Other (Specify)
Adult Residential Facility																
Congregate Living Health Facility																
Transitional Housing Emergency Housing																
Group Home/Specialized Group Home for Children																
Residential Care Facility for the Chronically Ill																
Transitional Housing																

*Describe night (10:00 p.m. to 7:00 a.m.) staffing ratios, if different from above.

11. For each substance abuse service type your organization offers, please provide the direct care staff to client ratio. If you have multiple sites with different staff ratios, please provide information for each site.

Substance Abuse Service Direct Care Staff to Client Ratio

SUBSTANCE ABUSE	RN*	LPN*	Nurse Practitioner	MD*	Physician Assistant	Residential Counselor*	Social Worker	Psychologist	Trained Counselor*	Psych. Tech.*	Activities Coordinator*	Other (Specify)
Residential Detoxification												
Residential Rehabilitation												
Substance Abuse Transitional Housing												
Outpatient Day Treatment												
Outpatient Methadone Maintenance												
Outpatient Methadone Detoxification												

*Describe night (10:00 p.m. to 7:00 a.m.) staffing ratios, if different from above.

12. Program-Related Staffing. Program-related staffing are those that are part of the operation of the settings in which treatment, either substance abuse or residential care, occurs. These staff and the services they provide are related to the programs that occur within these settings, but are not directly tied to direct care. These services will vary in the substance abuse and the residential care arena and may include aspects related to program support (i.e., supervision of direct care staff, program supplies, training, quality management, social services, case management, program-associated transportation).

12.a Residential Program Related (Non-Direct Care) Staffing — Number of Staff Per Service Type

Residential	Case Managers	Director of Nursing	Drivers – Client Transportation	Facility and other Managers	Food Service Employees	Housekeeping/Facility Maintenance	Medical Director	Quality Management Staff	Supervisors	Activities Coordinator	Other (Specify)
Adult Residential Facility											
Congregate Living Health Facility											
Transitional/Emergency Housing											
Group Home/Children											
Residential Care Facility for the Chronically Ill											
Transitional Housing											

12.b Substance Abuse Program Related (Non-Direct Care) Staffing — Number of Staff Per Service Type

Substance Abuse	Case Managers	Director of Nursing	Drivers – Client Transportation	Facility and other Managers	Food Service Employees	Housekeeping/Facility Maintenance	Medical Director	Quality Management Staff	Supervisors	Activities Coordinator	Other (Specify)
Residential Detoxification											
Residential Rehabilitation											
Substance Abuse Transitional Housing											
Outpatient Day Treatment											
Outpatient Methadone Maintenance											
Outpatient Methadone Detoxification											

Provider Interview Guide

13. Does your organization have a staff training plan?

- ☐ Yes ☐ No

If yes, briefly describe the training requirements you have in place.

14. Does your organization participate in an external accreditation review?

- ☐ Yes ☐ No

If yes, what is the accreditation/certification organization?

Which services are accredited or certified?

15. Does your organization use standards and/or practice guidelines to set performance and quality parameters?

- ☐ Yes ☐ No

If yes, please indicate which standards/guidelines you use.

Provider Interview Guide

16. Does your organization have a Quality Management Plan?

☐ Yes ☐ No

If yes, is this plan updated annually? ☐ Yes ☐ No

Describe a recent quality management initiative and the results.

17. Does your organization have a program tracking, evaluation, and reporting process?

☐ Yes ☐ No

If yes, what outcomes do you measure? Please provide examples.

Does your organization routinely develop reports? What types of information are in the reports and who reviews the reports?

18. Does your organization have a mechanism to track issues, complaints, and grievances to resolution?

☐ Yes ☐ No

If yes, is the mechanism automated? ☐ Yes ☐ No

Provider Interview Guide

What is the average/standard turnaround time for problem resolution?

☐ 24 hours ☐ 48 hours ☐ 1 week ☐ Other (specify)

19. Does your organization have a client/resident/family education program?

☐ Yes ☐ No

If yes, please describe how this works.

20. Does your organization conduct a client satisfaction survey or interviews?

☐ Yes ☐ No

If yes, please describe.

When was the most recent survey? What were the results?

Were there specific areas identified in the client satisfaction survey/method that you are targeted for improvements?

☐ Yes ☐ No

21. Are there any specific regulatory or financing barriers your organization faces in the delivery of services to persons with HIV disease or AIDS?

22. Is there anything else you would like to discuss about your organization pertaining to the rate setting or regulatory process?

This completes the interview. We will share the results with the County of Los Angeles, Department of Health Services, OAPP. Your responses will help identify key factors for the development of fair and equitable rates. If we have follow-up questions, we will contact you. Thank you for your time and assistance.

MERCER

Government Human Services Consulting

Mercer Human Resource Consulting, Inc.
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500



Marsh & McLennan Companies

APPENDIX D

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service definition adopted by the County of Los Angeles Department of Health Services/Office of AIDS Policy and Programs. This definition is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Adult Residential Facilities

LICENSURE CATEGORY

Adult Residential Facility¹

DEFINITIONS AND DESCRIPTIONS

Adult Residential Facilities (ARF): Facilities that provide 24-hour non-medical care and supervision for adults ages 18 through 59 who are unable to provide for their own daily needs. Such programs are designed to provide housing and support services including assistance in dressing, grooming, bathing and other personal hygiene; assistance with taking medication; central storing and/or distribution of medications; arrangement of, and assistance with, medical and dental care; maintenance of house rules for the protection of clients; supervision of client schedules and activities; maintenance and/or supervision of client cash resources or property; monitoring food intake or special diets; and other basic services required under Community Care facility licensure. Adults eligible for ARF services may be physically handicapped, developmentally disabled, and/or mentally disabled.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.² In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS.³ Clients with HIV/AIDS in an ARF setting require special attention particularly in relation to the coordination of a continuum

¹ Chapters 1 & 6, Division 6, Title 22, California Code of Regulations.

² AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

³ Presentation Materials - Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

of services including medical, psychological and social support services while residing in the facility. Additionally, risk assessment, transmission prevention and treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative clients in the facility.

PROGRAM REQUIREMENTS

The following are minimum requirements and standards for ARFs. Providers and individuals may exceed these standards.

- **General Requirements:** The program must ensure its ability to address the needs of the client by meeting the following general requirements:
 - Adult Residential Facility services are provided to persons who have HIV disease or AIDS and who are in need of housing, supervision, and non-medical care in a home-like setting.
 - Adult Residential Facilities must be licensed and operate in accordance with Chapters 1 and 6, Division 6, Title 22 of the California Code of Regulations.
 - The facility must ensure its ability to address the needs of the client by meeting the following general standards:⁴
 - provide 24-hour culturally competent, non-medical care, supervision and assistance (scheduled and unscheduled);
 - accept the assumption of responsibility for resident well-being, including safety and security (responsibility to monitor and assist to maintain well-being);
 - provide health-related services, as applicable, to state regulations;
 - minimize the need to move to other settings;
 - maximize the client's dignity, autonomy, privacy, independence, choice, and safety (including negotiated risk);
 - utilize collaborative decision making;
 - accommodate the client's changing needs and preferences within the scope of local and state regulations; and
 - encourage family and community involvement.
- **Intake and Assessment:**⁵ Prior to accepting a client into an adult residential facility, the person responsible for admissions must interview the prospective client and his/her authorized representative, including the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:
 - **Eligibility Determination:** Persons eligible for adult residential services have HIV/AIDS disease and are in need of housing.
 - **Assessment:** Includes age, the assessment of health status, including HIV prevention needs, family status family composition, special housing needs, level of independence/level of resources available to solve problems and comorbidity

⁴ Source: Revised from the Joint Commission. *2003-2005 Accreditation Manual for Assisted Living*. 2002, page 14.

⁵ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

factors.⁶ If the facility provides services for clients with mental illness, the facility administrator shall ensure that a written intake assessment is prepared by a licensed mental health professional prior to acceptance of the client. This assessment may be provided by a student intern if the work is supervised by a licensed mental health professional. Facility administrators may utilize placement agencies including, but not limited to, county clinics for referrals and assessments.⁷

➤ ***Client Education:*** If a prospective client is deemed eligible for intake, the facility staff shall provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules, activities, client rights and responsibilities, and grievance procedures. Further, client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS.⁸

- ***Needs and Services Plan:*** A needs and services plan must be developed for all clients based upon the initial assessment. This plan should serve as the framework for the type and duration of services provided during the client's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.
- ***Contagious and Infectious Disease Management:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
- ***Referral Services:*** In addition to primary medical services and case management, the facility shall have linkages with a continuum of culturally appropriate HIV/AIDS care and services and shall link and/or refer clients to these service options, including, but not limited to, behavioral health/mental health services, alcohol and substance abuse services, legal and financial services.⁹ Further, the facility should provide assistance with accessing insurance benefits and entitlements. For women of reproductive age

⁶ Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

⁷ Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

⁸ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

⁹ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

and families, the facility will assist with referrals to obtain reproductive health care and family services. The facility shall also assist the client with establishing linkages with other community supports, such as recreational and adult education programs. Referrals for services should be made at any point at which the needs of the client cannot be met by the facility within its established programs or services and should be documented as part of the individualized needs and services plan.

- If, during intake, it is determined that the residential support needs of the client cannot be met by the facility within its programs or services, then a referral must be made to an alternate provider or venue of services.
- If, after admission, observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral or transfer to another type of facility, the facility staff shall consult with the client and the appropriate specialist, as necessary, to assist in determining if such needs can be met by the facility within the facility's programs of services or if a referral and transfer is required.

- **Support Services:**¹⁰ Support services that are to be provided or coordinated must include but are not limited to:

- Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
- Health related services (e.g., medication management services)
- Transmission risk assessment and prevention counseling
- Social services
- Recreational activities
- Meals
- Housekeeping and laundry
- Transportation

In residential facilities with a licensed capacity of 50 or more clients, a current, written program of activities will be planned, in advance, and made available to all clients. Activities will be encouraged through provision of the space, equipment, and supplies, as well as provision of information and assistance with accessing community activities, such as recreation and adult education. For programs under 50 residents, activities will be planned with the residents and implemented on a regular basis.

- **Discharge Planning:**¹¹ Discharge planning services include, but are not limited to:
 - Linkage to primary medical care, emergency assistance and supportive services as appropriate.
 - Linkage to support services that enhance access to care (e.g., case management, meals, nutritional support, and transportation).

¹⁰ Assisted Living Work Group (ALW). A Report to the US Senate Special Committee on Aging. April, 2003, p. 12.

¹¹ Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White Care Act Housing Policy, U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau, with John Snow, Inc, and AIDS Housing of Washington under contract #240-96-0037.p. 22.

- Housing such as permanent housing, independent housing, supportive housing, or other available housing.
- **Monthly Case Conference:**¹² A monthly case conference should include review of the Individual Needs and Services Plan, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate. Attendees at the monthly case conference should include the client and direct care staff representatives responsible for ongoing assessment of the client's needs. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the client's approval. The client may also invite the participation of an advocate, family members or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and supports for the client.
- **Quality Management:** The program shall implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation and Quality Assessment and Management Reports.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹³

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Services Plan (INSP). (Goal – 100%)
2. Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%)

¹² Office of Aids Program and Policy Requirement.

¹³ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING¹⁴

The Adult Residential Facility must have the following staff:

- ***Administrative and Support Staff:***

- A certified administrator appointed by the licensee.
- An employee, designated by the administrator, with primary responsibility for the ARF. For facilities with a licensed capacity of 16 to 49 clients, this staff may have other responsibilities; for facilities with a licensed capacity of 50 or more clients, one full-time employee must be assigned responsibility for the ARF;
- Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- A food service employee, designated by the administrator to have primary responsibility for food planning, preparation, and service. For facilities with a licensed capacity of 16 to 49 clients, this employee may have other duties; for facilities with a licensed capacity of 50 or more clients, and which provide 3 meals a day, the designated food service employee must have full-time responsibility for the operation of the food service program.

Direct Care Staff: The facility will ensure that all direct services to clients are provided by staff who is trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. For daytime support, direct care staff must include:

- Employee(s) designated to perform admission, intake and assessment functions, including ongoing evaluation of the residents' supervision and care needs.
- An employee responsible for oversight and provision of planned activities, including oversight of volunteers. For facilities with a licensed capacity of 16 to 49 clients, the person responsible for planned activities may have other responsibilities; for facilities with a licensed capacity of 50 or more clients, the designated activities employee must be full time.
- Staff ratio of no less than 1 direct care staff to 3 clients for residents who require staff assistance to perform all activities of daily living.

For night supervision from 10:00 p.m. to 7:00 a.m. direct care staff must include:

- Facilities housing 15 or fewer clients – 1 staff person on call and on the premises;
- Facilities housing 16 to 100 clients – 1 staff person on duty, awake and on the premises;

¹⁴ Adapted from Chapter 6, Division x, Title 22, of the California Code of Regulations (CCR).

- Facilities housing 101 to 200 clients – at least 1 staff person on duty, on the premises and awake, and at least 1 staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes;
- Facilities housing 7 or more clients who rely upon others to perform all activities of daily living – at least 1 person on duty, on the premises, and awake at night; for every additional 14 such clients – 1 additional person on duty, on the premises, and awake at night.

LENGTH OF STAY

Indeterminate — until the client no longer meets criteria.

SERVICES

- *Development of the Needs and Services Plan:* The Needs and Services Plan should be developed with the client and should include the client's background, medical and mental/emotional functioning and the facility's plans for providing culturally appropriate services to meet the individual needs identified above. If the client has a restricted health condition, the Needs and Services Plan must include the Restricted Health Condition Care Plan.
- *Review/Reevaluation of the Needs and Services Plan:* The Plan should be updated as frequently as necessary to ensure its accuracy and to document significant occurrences that result in changes in the client's physical, mental, and/or social functioning. If modifications to the plan identify an individual client service need which is not being met by the facility, the facility must secure consultation to determine if the facility can meet the client service need. If it is determined that the client's needs cannot be met, the facility should assist with relocation of the client into an appropriate level of care.
- *Implementation of the Needs and Services Plan:* Services identified in the Needs and Services Plan should be provided directly, or the facility should link the client with outside resources. The facility will provide necessary personal assistance and care, as indicated in the Needs and Services Plan, with activities of daily living including, but not limited to, dressing, eating, and bathing.
- *Support and Coordination of Care Services:* The facility should provide the following assistance:
 - the provision and/or coordination of all services identified in the Needs and Services Plan;
 - assistance in dressing, grooming, bathing, and other personal hygiene;
 - assistance with taking medication;
 - central storing and/or distribution of medications;
 - arrangement of and assistance with medical and dental care;
 - maintenance of house rules for the protection of clients;
 - arrangement and managing of client schedules and activities; and
 - maintenance and/or management of client cash resources or property.

- *Laundry:* The facility will provide basic laundry services including washing and drying of the client's personal clothing.
- *Recreational Services:* The facility will ensure that planned recreational activities are provided for the clients. Each client who is capable will be given the opportunity to participate in the planning, preparation, conducting, clean-up, and critiquing of the activities. The facility will ensure that clients are given the opportunity to attend and participate in community activities including, but not limited to, the following:
 - worship services and activities of the client's choice;
 - community service activities;
 - community events including, but not limited to, concerts, tours, dances, play, and celebrations of special events;
 - self-help organizations; and
 - senior citizen groups, sports leagues, and service clubs.

MEDI-CAL COVERAGE

Adult residential facility is not a covered Medi-Cal service; however, some services, such as physician services, provided at the ARF may be covered under the Medi-Cal state plan.

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following is a service description for a Residential Care Facility for the Chronically Ill adopted by the County of Los Angeles Department of Health Services/Office of AIDS Policy and Programs. This definition is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Residential Care Facility for the Chronically Ill

LICENSURE CATEGORY

Residential Care Facility for the Chronically Ill¹

Note: A Residential Care Facility for the Chronically Ill must be licensed by the Community Care Licensing Department of the California Office of Regulations Development unless it is exempt from licensure, as specified in regulation.

DEFINITIONS AND DESCRIPTIONS

“Residential Care Facilities for the Chronically Ill” (RCFCI) means any place, building, or housing arrangement which is maintained and operated to provide care and supervision to all or any of the following:

- adults with HIV disease or AIDS,
- emancipated minors with HIV or AIDS, or
- family units with adults or children or both with HIV disease or AIDS.²

The capacity of a RCFCI may not exceed 50 beds.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.³ In the County of Los Angeles, it is estimated that more

¹ Section 1568.072, Health and Safety Code, cited in California DSS Manual CCL, 12/04/1996, page 16.

² Chapter 8.5, Division 6, Title 22, of the California Code of Regulations (CCR).

³ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

than 53,000 people are living with HIV/AIDS.⁴ Clients with HIV/AIDS require special attention particularly in relation to the coordination of a continuum of services including medical, psychological and social support services while residing in the facility. Additionally, risk assessment, transmission prevention and treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative residents in the facility.

PROGRAM REQUIREMENTS

- **General Requirements:** A facility may accept or retain the following clients whose condition has been diagnosed as chronic and life threatening and who require different levels of care, except those with conditions specified in regulation:
 - clients whose illness is in a state of remission;
 - clients whose illness is intensifying and causing deterioration in their condition, provided they do not require inpatient care in an Acute Care Hospital or a skilled nursing facility, as determined by the client's physician;
 - clients whose condition has deteriorated to a point where death is imminent; and
 - clients who have, in addition to the above, other medical conditions or needs or require the use of medical equipment, as long as the facility is able to meet statutory and regulation requirements when providing services to these clients.

The facility will not accept or retain a client who:

- requires in-patient care in an acute hospital;
- requires treatment and/or observation by the appropriately skilled professional for more than 8 hours per day in the facility;
- has communicable tuberculosis or any other reportable disease (except AIDS);
- requires 24-hour intravenous therapy;
- has a psychiatric condition(s) and is exhibiting behaviors which could present a danger to self or others;
- has a Stage II or greater decubitus ulcer;
- requires renal dialysis treatment in the facility;
- requires life support systems including, but not limited to, ventilators and respirators;
- has a diagnosis that does not include one denoting a chronic life-threatening illness;
- has a primary diagnosis of Alzheimer's; and
- has a primary diagnosis of Parkinson's Disease.⁵

- **Intake and Assessment:**⁶ Prior to accepting a client into residential care facilities for the chronically ill, the person responsible for admissions must interview the

⁴ Presentation Materials – Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁵ (1) Chapter 8.5, Division 6, Title 22, of the California Code of Regulations (CCR); (2) Authority Cited: Section 1568.072, Health and Safety Code. Reference: Sections 1568.01, 1568.03, and 1568.072, Health and Safety Code.

prospective client and his/her authorized representative, including the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:

- *Eligibility Determination:* Persons eligible for residential care facilities for the chronically ill have HIV/AIDS disease and are in need of housing and care and supervision. At the minimum, determination of eligibility should be based on housing status and financial eligibility and must meet the conditions described under General Program Requirements above. HIV status should be documented during the intake process.
- *Assessment:* Includes age, the assessment of health status, including HIV prevention needs, family status, record of medications and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level of resources available to solve problems, and comorbidity factors.⁷
 - Prior to or within 30 days of the acceptance of a client, the facility will obtain a written medical assessment of the client which enables the facility to determine his/her ability to provide the necessary health-related services required by the client's medical condition. Such assessment will be performed by, or under the supervision of, a licensed physician and should not be more than 3 months old when obtained. If the assessment is not completed prior to admission of the client, a Registered Nurse must provide a health assessment within 24-hours of admission to determine if any immediate health needs are present which may preclude placement.
 - If the facility provides services for residents with mental illness, the facility administrator shall ensure that a written intake assessment is prepared by a licensed mental health professional prior to acceptance of the client. This assessment may be provided by a student intern if the work is supervised by a licensed mental health professional. Facility administrators may utilize placement agencies, including, but not limited to, county clinics for referrals and assessments.⁸
- *Resident Education:* If a prospective client is deemed eligible for intake, the facility staff shall provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures. Further, client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS.⁹

⁶ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

⁷ Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

⁸ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

⁹ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

- ***Needs and Services Plan:***¹⁰ A needs and services plan must be developed for all clients prior to admission based upon the initial assessment. This plan should serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The Plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.
- ***Contagious and Infectious Disease Management:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine treatment options and suitability of the client's retention in the program.
- ***Referral Services:*** In addition to primary medical services and case management, the facility shall have linkages to a continuum of culturally appropriate HIV/AIDS care and services and shall link and/or refer clients to these service options, including, but not limited to, behavioral health/mental health services, alcohol and substance abuse services, legal and financial services.¹¹ Further, the facility should provide assistance with accessing insurance benefits and entitlements. For women of reproductive age and families, the facility should assist with referrals to obtain reproductive health care and family services. The facility should also assist the client with establishing linkages with other community supports, such as recreational and adult education programs.¹² Referrals for services should be made at any point at which the needs of the client cannot be met by the facility within its established programs or services and should be documented as part of the individualized needs and services plan.
 - If, during intake, it is determined that the residential support needs of the client cannot be met by the facility within its programs or services, then a referral must be made to an alternate provider or venue of services.
 - If, after admission, observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral or transfer to another type of facility, the facility staff shall consult with the client and the appropriate specialist, as necessary, to assist in determining if such needs can be met by the facility within the facility's programs of services or if a referral and transfer is required.

¹⁰ Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, and 1531, Health and Safety Code.

¹¹ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

¹² Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

- **Support Services:**¹³ Support services that are to be provided or coordinated must include but are not limited to:
 - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
 - Health related services (e.g. medication management services)
 - Transmission risk assessment and prevention counseling
 - Social services
 - Recreational activities
 - Meals
 - Housekeeping and laundry
 - Transportation.

- **Monthly Case Conference**¹⁴: A monthly case conference should include review of the Individual Needs and Services Plan, including the client's health and housing status, the need for and use of medical and other support services, and progress towards discharge, as appropriate. Attendees at the monthly case conference should include the client, the registered nurse case manager, and direct care staff representatives. Participants can include housing coordination staff and/or representatives from other community organizations, subject to the client's approval. The client may also invite the participation of an advocate, family members or other representative. The case conference must be documented and include outcomes, participants, and any specific steps necessary to obtain services and supports for the client.

- **Discharge Planning**¹⁵: Discharge planning services include, but are not limited to:
 - Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate.
 - Linkage to support services that enhance access to care (e.g., case management, meals, nutritional support, and transportation).
 - Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing, and referral.
 - Housing such as permanent housing, independent housing, supportive housing, long-term assisted living, or other available housing.

- **Quality Management**: The program should implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality

¹³ Assisted Living Work Group (ALW). A Report to the US Senate Special Committee on Aging. April, 2003, p. 12.

¹⁴ Office of Aids Program and Policy Requirement.

¹⁵ Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White Care Act Housing Policy, U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau, with John Snow, Inc, and AIDS Housing of Washington under contract #240-96-0037.p. 22.

Indicators, QM Plan Implementation and Quality Assessment and Management Reports.

- ***Cultural Competence:*** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹⁶

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Services Plan (INSP). (Goal – 100%)
2. Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING

The Residential Care Facilities for the Chronically Ill must have the staff qualified to manage the facility; supervise operations on a 24-hour basis as necessary; and maintain records as required by the Office of AIDS Programs and Policy (OAPP). Further, all staff should be trained on HIV-related and confidentiality issues.

- ***Administrative and Support Staff:***
 - A certified administrator appointed by the licensee (unless exempt from licensure).
 - An employee designated by the administrator, with primary responsibility for the Residential Care Facilities for the Chronically Ill.

¹⁶ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

- Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- **Direct Care Staff:**
The facility will ensure that all direct services to clients are provided by staff trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.
 - A Registered Nurse Case Manager is responsible for the provision and/or coordination of the services, specified in the Needs and Services Plan.
 - In addition to the Registered Nurse Case Manager, the following persons will constitute the Individual Services Team and will be involved in the development and updating of the client's Needs and Services Plan:
 - the client and/or his/her authorized representative;
 - the client's physician;
 - facility house manager;
 - direct care personnel;
 - social worker/placement worker;
 - pharmacist, if needed;
 - for each un-emancipated minor, the child's parent or guardian and the person who will assume legal custody and control of the child upon the hospitalization, incapacitation, or death of the parent or guardian; and
 - other, as deemed necessary.
 - At least one direct care staff person must be on duty whenever residents are present.
 - For daytime hours, the minimum staffing ratio should be one direct care staff person up, awake, and on duty for every ten residents on the premises.
 - For evening and night hours, the minimum staffing is one direct care staff person up, awake, and on duty for every fifteen residents on the premises.
 - For evening and night hours, at least one direct care staff person must be on call within 30 minutes of the facility in case of an emergency.
 - For residents who are unable to assist in the performance of activities of daily living and for residents whose death is imminent, the direct care staffing ratio should be one direct care staff person to every three residents.

LENGTH OF STAY

Indeterminate — until the client no longer meets criteria.

SERVICES

- *Development of the Needs and Services Plan:* The Needs and Services Plan should be developed with the client and should include the client's background, medical and mental/emotional functioning and the facility's plans for providing services to meet the individual needs identified above. If the client has a restricted health condition, the Needs and Services Plan must include the Restricted Health Condition Care Plan.

- *Review/Reevaluation of the Needs and Services Plan:* The Plan should be updated as frequently as necessary to ensure its accuracy and to document significant occurrences that result in changes in the client's physical, mental, and/or social functioning. If modifications to the plan identify an individual client service need which is not being met by the facility, the facility must secure consultation to determine if the facility can meet the client service need. If it is determined that the client's needs cannot be met, the facility should assist with relocation of the client into an appropriate level of care.
- *Implementation of the Needs and Services Plan:* Services identified in the Needs and Services Plan should be provided directly or the facility should link the client with outside resources. The facility will provide necessary personal assistance and care, as indicated in the Needs and Services Plan, with activities of daily living including, but not limited to, dressing, eating, and bathing.
- *Support and Coordination of Care Services:* The facility should provide the following assistance:
 - the provision and/or coordination of all services identified in the Needs and Services Plan;
 - assistance in dressing, grooming, bathing, and other personal hygiene;
 - assistance with taking medication;
 - central storing and/or distribution of medications;
 - arrangement of and assistance with medical and dental care;
 - maintenance of house rules for the protection of clients;
 - arrangement and managing of client schedules and activities; and
 - maintenance and/or management of client cash resources or property.¹⁷
- *Laundry:* The facility will provide basic laundry services including washing and drying of the client's personal clothing.
- *Recreational Services:* The facility will ensure that planned recreational activities are provided for the clients. Each client who is capable will be given the opportunity to participate in the planning, preparation, conducting, clean-up, and critiquing of the activities. The facility will ensure that clients are given the opportunity to attend and participate in community activities including, but not limited to, the following:
 - worship services and activities of the client's choice;
 - community service activities;
 - community events including, but not limited to, concerts, tours, dances, play, and celebrations of special events;
 - self-help organizations; and
 - senior citizen groups, sports leagues, and service clubs.

MEDI-CAL COVERAGE

Residential Care Facility for the Chronically Ill is not a covered Medi-Cal service; however, some services, such as physician services, provided at the facility may be covered under the Medi-Cal state plan.

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service definition adopted by the County of Los Angeles Department of Health Services/Office of AIDS Policy and Programs. This definition is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Residential/Congregate Living Health Facility

LICENSURE CATEGORY

Congregate Living Health Facility — requires certification as a Hospice Provider¹

DEFINITIONS AND DESCRIPTIONS

“Congregate Living Health Facility” (CLHF) means a residential home with a capacity of no more than 6 beds (except under limited circumstances allowed by regulation) that provides inpatient care, including the following basic services:

- medical supervision;
- 24-hour skilled nursing; and
- supportive care, including pharmacy, dietary, social, recreational, and other services defined in regulation.²

The primary need of CLHF clients is availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

“HIV/AIDS CLHF³ service” is 24-hour inpatient care provided to persons with symptomatic HIV disease or AIDS in a residential home (non-institutional, home-like environment).

“Hospice”⁴ means a public agency or private organization, or a subdivision thereof, or a facility which:

¹County contract with AIDS Healthcare Foundation, February 26, 2002.

²California Health and Safety Code Section 1250 a (i)(1).

³LA County contract with AIDS Healthcare Foundation, February 26, 2002.

⁴ California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, §51180.

- is primarily engaged in providing required items and services to terminally ill individuals;
- makes such services available as needed on a 24-hour basis; and
- provides bereavement counseling for the immediate family and significant others.

“Hospice Care”⁵ means the provision of services in a humanitarian way for the patient to approach death with dignity, in relative comfort in a supportive atmosphere, and surrounded by family members/significant others. Hospice advocates personal care and concern, living comfortably until death, the absence of pain, maintenance of personal control, and treats the patient, family, and significant other as the unit of care.

A “life-threatening illness” means the individual has an illness that can lead to a possibility of a termination of life within 5 years or less, as stated in writing by his or her attending physician and surgeon.

“Terminally ill”⁶ means that an individual’s medical prognosis, as certified by a physician, is that his or her life expectancy is 6 months or less.⁷ The physician’s certification must be accompanied by “specific clinical findings and other documentation that support the medical prognosis” and be “filed in the medical record” with the written certification.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.⁸ In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS.⁹ Clients with HIV/AIDS in a Congregate Living Health Facility require special attention particularly in relation to the coordination of a continuum of services including medical, psychological and social support services while residing in the facility. Additionally, risk assessment, transmission prevention and treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative residents in the facility.

PROGRAM REQUIREMENTS

- **General Requirements:** The congregate health facility must ensure its ability to meet the needs of the client by meeting the following general standards:¹⁰
 - provide 24-hour culturally competent, medical care, supervision and assistance (scheduled and unscheduled);

⁵ LA County contract with AIDS Healthcare Foundation, February 26, 2002.

⁶ California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, §51180.

⁷ Code of Federal Regulations (Title 42 Section 42 CFR 418.22(b)(2)).

⁸ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁹ Presentation Materials – Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

¹⁰ Source: Revised from the Joint Commission. *2003-2005 Accreditation Manual for Assisted Living*. 2002, page 14.

- accept the assumption of responsibility for resident well-being, including safety and security (responsibility to monitor and assist to maintain well-being);
 - provide health-related services, as applicable, to state regulations;
 - minimize the need to move to other settings;
 - maximize the client's dignity, autonomy, privacy, independence, choice, and safety (including negotiated risk);
 - utilize collaborative decision making;
 - accommodate the client's changing needs and preferences within the scope of local and state regulations; and
 - encourage family and community involvement.
- ***Intake and Assessment:***¹¹ Prior to accepting a client into a congregate health living facility/hospice, the person responsible for admissions must interview the prospective client and his/her authorized representative, including the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:
 - ***Eligibility Determination:*** To be eligible for a congregate health living facility, persons must have symptomatic HIV/AIDS in a "life-threatening stage as stated in writing by his or her attending physician and surgeon. Persons eligible for hospice care for the chronically ill have HIV/AIDS disease and must be certified by a physician as terminally ill.
 - ***Assessment:*** Includes age, the assessment of health status, including HIV prevention needs, family status, need for palliative care, age, health status, record of medications and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level of resources available to solve problems, and comorbidity factors.¹²
 - ***Resident Education:*** If a prospective client is deemed eligible for intake, the facility staff should provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.¹³
 - ***Advanced Directives:*** If a prospective client is deemed eligible for intake, the facility staff should discuss preparation of an Advanced Directive and assist the client to complete one, if desired.
 - ***Needs and Services Plan:***¹⁴ A needs and service plan must be developed for all clients prior to admission based upon the initial assessment. This plan should serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning, and need for palliative care.

¹¹ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

¹² Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

¹³ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁴ Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, and 1531, Health and Safety Code.

- ***Contagious and Infectious Disease Management:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
- ***Referral Services:*** Referrals for services should be made at any point at which the needs of the client cannot be met by the facility within its established programs or services and should be documented as part of the individualized needs and services plan.
- ***Support Services.*** Support services that are to be provided or coordinated must include but are not limited to:
 - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
 - Health related services (e.g. medication management services)
 - Social services
 - Family bereavement counseling
 - Recreational activities
 - Meals
 - Housekeeping and laundry
 - Transportation
- ***Quality Management:*** The program should implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation and Quality Assessment and Management Reports.
- ***Cultural Competence:*** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹⁵

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Service Plan (INSP). (Goal – 100%)

¹⁵ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

2. Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING

The Congregate Living Health Facility must have staff qualified to manage the facility; supervise operations on a 24-hour basis, as necessary; and maintain records as required by the Office of AIDS Program and Policy (OAPP). Further all staff should be trained on HIV-related and confidentiality issues.¹⁶ Additional staffing requirement are noted below:

- ***Administrative and Support Staff:***
 - A certified administrator appointed by the licensee.
 - An employee, designated by the administrator, with primary responsibility for the facility.
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
 - A director of nursing that does not have charge nurse responsibilities.
 - A dietician must be employed on a full time, part-time or consulting basis.
 - A consulting pharmacist must review drug regimen of each patient at least monthly and prepare appropriate reports.
 - Full-time, part-time or consulting activities program staff with appropriate training and experience must be available to provide activities based on the needs and interests of clients.
 - A full, part-time or consulting social worker should be available clients.
- ***Direct Care Staff:*** The facility will ensure that all direct services to clients are provided by staff trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.

¹⁶ P.A.T.H. People Assisting the Homeless Contract with the County of Los Angeles, February 26, 2002.

- The hospice must provide nursing care and services by or under the supervision of a registered nurse and it must provide adequate nursing care to meet the needs of the patient.
- Home health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients.
- A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.
- Drugs and biologicals are administered only by the following individuals: (1) a licensed nurse or physician, (2) an employee who has completed a State-approved training program in medication administration, (3) the patient, if his or her attending physician has approved, or (4) any other individual in accordance with applicable State and local laws. The persons, and each drug and biological they are authorized to administer, must be specified in the patient's plan of care.
- Medical social services when provided by a social worker with at least a Bachelor's degree in social work, from a school approved or accredited by the council on Social Work Education, under the direction of a physician.
- Facilities licensed for 59 or fewer beds must have at least one registered nurse or a licensed vocational nurse, awake and on duty, in the facility at all times, day and night.
- Facilities licensed for 60-99 beds shall have at least one registered nurse or licensed vocational nurse, awake and on duty in the facility at all times, day and night, in addition to a director of nursing services. The director of nursing services may not perform charge nurse responsibilities.
- Facilities licensed for 100 or more beds must have at least one registered nurse, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing. The director of nursing services may not perform charge nurse responsibilities.
- Each facility must employ sufficient nursing staff to provide a minimum daily average of 3.0 nursing hours per patient per day.
- Full time, part time or consulting occupational therapist may be available to meet the needs of the client (this is an optional service).
- Full-time, part-time, or consulting physical therapist may be available to meet the needs of the client (this is an optional services).

LENGTH OF STAY

Indeterminate — until the client no longer meets criteria.

SERVICES

Congregate living health facilities should provide one of the following services¹⁷:

- Service for mentally alert, physically disabled persons, who may be ventilator dependent.

¹⁷ California Health and Safety code, Section 1250 a (i)(1).

- Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both, including, but not limited to:
 - residential services,
 - medical supervision,
 - 24-hour skilled nursing and supportive care,
 - pharmacy services,
 - laundry services
 - dietary services, and
 - social recreational services.
- Services for persons who are catastrophically and severely disabled. A catastrophically and severely disabled person means a person whose origin of disability was acquired through trauma or non-degenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a catastrophically disabled person should include, but not be limited to, speech, physical, and occupational therapy.¹⁸
- Hospice care, including the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition by a hospice provider or by others under arrangements made by a hospice provider:
 - nursing services;
 - physical or occupational therapy or speech-language pathology;
 - medical social services under the direction of a physician;
 - home health aide and homemaker services;
 - medical supplies and appliances;
 - drugs and biologicals;
 - physician services;
 - short-term inpatient care;
 - counseling, including bereavement, dietary, and spiritual counseling; and
 - any other item or service for which payment may otherwise be made under the Medi-Cal program.
- For palliative care,¹⁹ the congregate living facility will provide, within its scope of services offered, timely care and support for each resident so that he/she may live as fully and as comfortably as possible within the context of the resident's values and symptoms. These outcomes are accomplished when:
 - The resident is provided with accurate and timely information to make treatment decisions.
 - The service plan supports the resident's choices that are consistent with the resident's advance directives, values, spiritual preferences, and life-long living patterns, even though these decisions may involve increased risk or personal harm to the resident.

¹⁸ LA County contract with AIDS Healthcare Foundation, February 26, 2002.

¹⁹ The Assisted Living Workgroup. A Report to the US Senate Special Committee on Aging. April, 2003, p. 133.

MEDI-CAL COVERAGE

Hospice service is a covered Medi-Cal service.

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service definition adopted by the County of Los Angeles Department of Health Services/Office of AIDS Programs and Policy. This definition is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Residential Hospice Facility

LICENSURE CATEGORY

Requires licensure as a Residential Care Facility for the Chronically Ill, Congregate Living Health Facility, or a Nursing Facility Level B with certification as a Hospice Provider¹.

DEFINITIONS AND DESCRIPTIONS

Residential Hospice means a residential home that provides supportive care, including nursing, pharmacy, dietary, recreational, and other medical and social services.

“Hospice”² means a public agency or private organization, or a subdivision thereof, or a facility which:

- is primarily engaged in providing required items and services to terminally ill individuals;
- makes such services available as needed on a 24-hour basis; and
- provides bereavement counseling for the immediate family and significant others.

“Hospice Care”³ means the provision of services in a humanitarian way for the patient to approach death with dignity, in relative comfort in a supportive atmosphere, and surrounded by family members/significant others. Hospice advocates personal care and concern, living comfortably until death, the absence of pain, maintenance of personal control, and treats the patient, family, and significant other as the unit of care.

¹ County contract with AIDS Healthcare Foundation, February 26, 2002.

² California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, §51180.

³ LA County contract with AIDS Healthcare Foundation, February 26, 2002.

“Terminally ill”⁴ means that an individual’s medical prognosis, as certified by a physician, is that his or her life expectancy is 6 months or less.⁵ The physician’s certification must be accompanied by “specific clinical findings and other documentation that support the medical prognosis” and be “filed in the medical record” with the written certification.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.⁶ In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS.⁷ Clients with HIV/AIDS in a Residential Hospice Facility require special attention particularly in relation to the coordination of a continuum of services including medical, psychological and social support services while residing in the facility. Additionally, risk assessment, transmission prevention and treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative residents in the facility.

PROGRAM REQUIREMENTS

- **General Requirements:** The Residential Hospice Facility must ensure its ability to meet the needs of the client by meeting the following general standards:⁸
 - provide 24-hour culturally competent, medical care, supervision and assistance (scheduled and unscheduled);
 - accept the assumption of responsibility for resident well-being, including safety and security (responsibility to monitor and assist to maintain well-being);
 - provide health-related services, as applicable to state regulations and licensure requirements;
 - minimize the need to move to other settings;
 - maximize the client’s dignity, autonomy, privacy, independence, choice, and safety (including negotiated risk);
 - utilize collaborative decision making;
 - accommodate the client’s changing needs and preferences within the scope of local and state regulations; and
 - encourage family and community involvement.

⁴ California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 2, §51180.

⁵ Code of Federal Regulations (Title 42 Section 42 CFR 418.22(b)(2)).

⁶ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁷ Presentation Materials – Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁸ Source: Revised from the Joint Commission. *2003-2005 Accreditation Manual for Assisted Living*. 2002, page 14.

- ***Intake and Assessment:***⁹ Prior to accepting a client into a Residential Hospice Facility, the person responsible for admissions must interview the prospective client and his/her authorized representative, and the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:
 - ***Eligibility Determination:*** To be eligible for a Residential Hospice Facility, persons must have HIV/AIDS, must be certified by a physician as terminally ill and must have OAPP Medical Director authorization prior to or within 72 hours of admission.

During the six months authorization, should a client no longer meet the criteria of terminally ill, the client should be transitioned to another stable living environment.

- ***Assessment:*** Includes age, the assessment of health status, including HIV prevention needs, family status, need for palliative care, age, health status, record of medications and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level of resources available to solve problems, and comorbidity factors.¹⁰
 - ***Resident Education:*** If a prospective client is deemed eligible for intake, the facility staff should provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.¹¹
 - ***Advanced Directives:*** If a prospective client is deemed eligible for intake, the facility staff should discuss preparation of an Advanced Directive and assist the client to complete one, if desired.
- ***Needs and Services Plan:***¹² A needs and service plan must be developed for all clients prior to admission based upon the initial assessment. This plan should serve as the framework for the type and duration of services provided during the client's stay in the facility and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning, and need for palliative care.
- ***Contagious and Infectious Disease Management:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS).

⁹ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

¹⁰ Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

¹¹ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹² Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, and 1531, Health and Safety Code.

If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.

- **Referral Services:** Referrals for services should be made at any point at which the needs of the client cannot be met by the facility within its established programs or services and should be documented as part of the individualized needs and services plan.
- **Support Services.** Support services that are to be provided or coordinated must include but are not limited to:
 - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
 - Health related services (e.g. medication management services)
 - Social services
 - Family bereavement counseling
 - Recreational activities
 - Meals
 - Housekeeping and laundry
 - Transportation
- **Quality Management:** The program should implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation and Quality Assessment and Management Reports.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹³

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Service Plan (INSP). (Goal – 100%)
2. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation, pain management, and services received through the Hospice program. (Goal – 90%)

¹³ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

REQUIRED STAFFING

The Residential Hospice Facility must have staff qualified to manage the facility; supervise operations on a 24-hour basis, as necessary; and maintain records as required by OAPP. Further all staff should be trained on HIV-related and confidentiality issues.¹⁴ Additional staffing requirements are noted below:

- ***Administrative and Support Staff:***
 - A certified administrator appointed by the licensee.
 - An employee, designated by the administrator, with primary responsibility for the facility.
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
 - A director of nursing that does not have charge nurse responsibilities.
 - A dietician must be employed on a full time, part-time or consulting basis.
 - A consulting pharmacist must review drug regimen of each patient at least monthly and prepare appropriate reports; and
 - Full-time, part-time or consulting activities program staff with appropriate training and experience must be available to provide activities based on the needs and interests of clients.
- ***Direct Care Staff:*** The facility will ensure that all direct services to clients are provided by staff trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.
 - The hospice must provide nursing care and services by or under the supervision of a registered nurse and it must provide adequate nursing care to meet the needs of the patients.
 - Drugs and biologicals are administered only by the following individuals: (1) a licensed nurse or physician, (2) an employee who has completed a State-approved training program in medication administration, (3) the patient, if his or her attending physician has approved, or (4) any other individual in accordance with applicable State and local laws. The persons, and each drug and biological they are authorized to administer, must be specified in the patient's plan of care.
 - Medical social services when provided by a social worker with at least a Bachelor's degree in social work, from a school approved or accredited by the council on Social Work Education, under the direction of a physician.
 - At least one direct care staff person must be on duty whenever residents are present.
 - For daytime hours, the minimum staffing ratio should be one direct care staff person up, awake, and on duty for every 10 residents on the premises.
 - For evening and night hours, the minimum staffing is one direct care staff person up, awake, and on duty for every fifteen residents on the premises.
 - For residents who are unable to assist in the performance of activities of daily living and for residents whose death is imminent, the direct care staffing ratio should be one direct care staff person to every three residents.

¹⁴ P.A.T.H. People Assisting the Homeless Contract with the County of Los Angeles, February 26, 2002.

- Full time, part time or consulting occupational therapist may be available to meet the needs of the client (this is an optional service).
- Full-time, part-time, or consulting physical therapist may be available to meet the needs of the client (this is an optional services).

LENGTH OF STAY

Up to six months as certified by the physician or until the client no longer meets criteria. Any extensions beyond the six month length of stay require recertification by the physician and authorization by the OAPP Medical Director.

SERVICES

Residential Hospice Facilities should provide the following services¹⁵:

- Services for persons who have a diagnosis of terminal illness including, but not limited to:
 - residential services,
 - medical supervision,
 - nursing and supportive care,
 - pharmacy services,
 - laundry services, and
 - dietary services.
- Hospice care, including the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition:
 - nursing services;
 - physical or occupational therapy or speech-language pathology;
 - medical social services under the direction of a physician;
 - medical supplies and appliances;
 - drugs and biologicals;
 - physician services;
 - counseling, including bereavement, dietary, and spiritual counseling; and
 - any other item or service for which payment may otherwise be made under the Medi-Cal program.
- For palliative care,¹⁶ the Residential Hospice Facility will provide, within its scope of services offered, timely care and support for each resident so that he/she may live as fully and as comfortably as possible within the context of the resident's values and symptoms. These outcomes are accomplished when:
 - The resident is provided with accurate and timely information to make treatment decisions.

¹⁵ California Health and Safety code, Section 1250 a (i)(1).

¹⁶ The Assisted Living Workgroup. A Report to the US Senate Special Committee on Aging. April, 2003, p. 133.

- The service plan supports the resident's choices that are consistent with the resident's advance directives, values, spiritual preferences, and life-long living patterns, even though these decisions may involve increased risk or personal harm to the resident.

MEDI-CAL COVERAGE

Residential Hospice Facility services are a covered Medi-Cal service.

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County of Los Angeles Department of Health Services/Office of AIDS Policy and Programs. This description is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Residential Emergency Housing

LICENSURE CATEGORY

Not necessarily licensed, but may be if client is placed in an adult residential facility, a community care facility, a transitional housing facility, or a congregate living facility on a temporary, emergency basis.

DEFINITIONS AND DESCRIPTIONS

HIV/AIDS “residential emergency housing” is temporary housing for homeless individuals with HIV disease or AIDS who require immediate living quarters.

“Homeless” persons are defined as individuals with HIV-disease or AIDS who lack a fixed, regular, and adequate residence or reside in: 1) a shelter designed to provide temporary, emergency living accommodations; 2) an institution that provides a temporary residence for individuals intended to be institutionalized; or 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.¹

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.² In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS.³ Clients with HIV/AIDS in residential

¹ P.A.T.H. People Assisting the Homeless contract with the County of Los Angeles, February 26, 2002.

² AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

emergency housing services require special attention particularly in relation to the coordination of a continuum of services including medical, psychological and social support services while residing in the facility. Additionally, risk assessment, transmission prevention and treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative residents in the facility.

PROGRAM REQUIREMENTS

General Requirements: HIV/AIDS residential emergency housing services are provided to persons who are homeless and who have HIV disease or AIDS.

- For licensed services operating an adult residential facility, a community care facility, a transitional housing facility, or a congregate living facility which offer residential emergency housing on a temporary, emergency basis, general program requirements are established in standards describing that service.³
- For residential emergency housing services which are not licensed,⁴ requirements include:
 - Each facility will have and maintain on file a current, written, definitive plan of operation, including admission policies and procedures regarding acceptance of clients, a copy of the admission agreement, staffing plan, qualifications and duties, and a plan for in-service education of staff if required by regulations governing the specific facility category;
 - The facility will assist with transportation arrangements for clients who do not have independent arrangements;
 - The facility will provide ample opportunities for family participation in activities in the facility; and
 - If the facility intends to admit and/or specialize in care for one or more clients who have a propensity for behaviors that result in harm to self or others, the plan of operation will include a description of precautions that will be taken to protect that client and all other clients.
- **Intake and Assessment:** The nature of emergency housing may preclude having important information prior to admission of the client. Upon acceptance of a client into residential emergency housing, the person responsible for admissions must interview the prospective client and his/her authorized representative, including the assigned case manager, if any, as soon as reasonably possible, to complete the following goals and document the intake and assessment findings:
 - **Eligibility Determination:** Persons eligible for residential emergency housing have HIV/AIDS disease and are in need of emergency housing. At the minimum, determination of eligibility should be based on housing status and financial eligibility. HIV status should also be documented during the intake process.⁵
 - **Assessment:** Includes age, the assessment of health status, including HIV prevention needs, family status, family composition, special housing needs, level

³ P.A.T.H. People Assisting the Homeless contract with the County of Los Angeles, February 26, 2002.

⁴ Excerpted from Chapters 2 through 7 and Chapter 9, Division 6, Title 22 California Code of Regulations.

⁵ Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

of independence/level of resources available to solve problems and comorbidity factors.⁶ The focus of the assessment is to identify strengths and gaps in the person's support system for the purpose of identifying permanent housing.

- **Resident Education:** Upon intake, the facility staff should provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures. Further, resident education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS.⁷
- **Needs and Services Plan:**⁸ The focus of the needs and services plan is to identify resources for permanent housing and referral to appropriate medical and social services.
- **Contagious and Infectious Disease Management:** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. The nature of emergency housing may preclude having important information prior to admission of the client. However, whenever possible, the client must be observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
- **Referral Services:** In addition to transitional or permanent housing, primary medical services and case management, the facility should have linkages to a continuum of culturally appropriate HIV/AIDS care and services and should link and/or refer clients to these service options, including but not limited to, behavioral health/mental health services, alcohol and substance abuse services, legal and financial services.⁹
- **Support Services:**¹⁰ Support services that are to be provided or coordinated must include but are not limited to:
 - Health related services (e.g., medication management services)
 - Transmission risk assessment and prevention counseling
 - Social services
 - Housekeeping and laundry

⁶ Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

⁷ Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, and 1531, Health and Safety Code.

⁸ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

⁹ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, June 2002, p. 13.

¹⁰ Assisted Living Work Group (ALW). A Report to the US Senate Special Committee on Aging. April, 2003, p. 12.

- Transportation
- **Discharge Planning:**¹¹ Discharge planning services include, but are not limited to:
 - Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate.
 - Linkage to support services that enhance access to care (e.g. case management, meals, nutritional support, transportation)
 - Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing, and referral.
 - Housing such as permanent housing, independent housing, supportive housing, or other available housing.
- **Quality Management:** The program should implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation and Quality Assessment and Management Reports.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹²

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Services Plan (INSP). (Goal – 100%)
2. Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%)

¹¹ Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White Care Act Housing Policy, U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau, with John Snow, Inc, and AIDS Housing of Washington under contract #240-96-0037.p. 22.

¹² Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP.
(Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFF

The Residential Emergency Housing must have staff qualified to manage the facility, supervise operations on a 24-hour basis, and maintain records as required by the Office of AIDS Programs and Policy (OAPP). Further, all staff should be trained on HIV-related and confidentiality issues.¹³ For licensed facilities operating an adult residential facility, a community care facility, or a congregate living facility which offer residential emergency housing, staffing requirements are established in regulations describing those services. For programs that do not fall into these licensure categories but provide emergency housing services, the staffing requirements include, but are not limited to:

- ***Administrative and Support Staff:***
 - An employee, with primary responsibility for the facility
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds
- ***Direct Care Staff:*** The facility will ensure that all direct services to clients are provided by staff trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.

For daytime support, direct care staff must include:

- Employee(s) designated to perform admission, intake and assessment functions, including ongoing evaluation of the residents' supervision and care needs.
- An employee responsible for oversight and provision of planned activities, including oversight of volunteers. For facilities with a licensed capacity of 16 to 49 clients, the person responsible for planned activities may have other responsibilities; for facilities with a licensed capacity of 50 or more clients, the designated activities employee must be full time.
- Staff ratio of no less than 1 direct care staff to 3 clients for residents who require staff assistance to perform all activities of daily living.

For night supervision from 10:00 p.m. to 7:00 a.m., direct care staff must include:

- Facilities housing 15 or fewer clients – 1 staff person on call and on the premises.
- Facilities housing 16 to 100 clients – 1 staff person on duty, awake and on the premises.

¹³ P.A.T.H. People Assisting the Homeless contract with the County of Los Angeles, February 26, 2002.

- Facilities housing 101 to 100 clients – at least 1 staff person on duty, on the premises and awake, and at least 1 staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes.
- Facilities housing 7 or more clients who rely upon others to perform all activities of daily living – at least 1 person on duty, on the premises, and awake at night; for every additional 14 such clients – 1 additional person on duty, on the premises, and awake at night.

LENGTH OF STAY

Individuals receiving services require interim housing from one night to a maximum of four weeks in order to stabilize and seek more permanent housing.

SERVICES

- Services include the following:
 - Lodging in a secured facility with individual rooms that are clean, safe, comfortable, and alcohol and drug free.
 - Three balanced and complete meals per day (referrals to missions or soup kitchens are not acceptable alternatives).
 - Adequate heating and lighting, plumbing, hot and cold water, toiletries, and bathing facilities.
 - Accessible telephone in working condition, available for clients to make local phone calls that are job, family, or housing related.
 - Laundry services or facilities.
 - Referral services to housing, case management, medical and social services.

MEDI-CAL COVERAGE

Emergency Housing is not a Medi-Cal covered service; however, some services, such as physician services, provided at the facility may be covered under the Medi-Cal state plan.

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County of Los Angeles Department of Health Services/Office of AIDS Policy and Programs. This description is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Residential Licensed Community Care

LICENSURE CATEGORY

Group Home for Children/Specialized Group Home ¹

DEFINITIONS AND DESCRIPTIONS

Group Home means any group home of any capacity which provides 24-hour care and supervision on a temporary or long term basis to children in a structured environment with such services provided at least in part by staff employed by the licensee.² The care and supervision provided is non-medical except as permitted by Welfare and Institutions Code Section 177736(b) Specialized Group Homes. A Specialized Group Home is a type of group home that provides services to children with special health care needs. This service description applies to Specialized Group Homes.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.³ In the County of Los Angeles, it is estimated that more than 53,000 adults and children are living with HIV/AIDS.⁴ Children with HIV/AIDS in a Group Home setting require special attention particularly in relation to the coordination of a continuum of services including medical, psychological and social support services while residing in the home. Additionally, risk assessment, transmission prevention and

¹ Chapter 1 and 5, Division 6, Title 22 California Code of Regulations.

² Division 6, Chapter 1, Article 1, Title 22, California Code of Regulations.

³ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁴ Presentation Materials – Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative children in the home.

PROGRAM REQUIREMENTS

The following are minimum requirements and standards for Group Homes. Providers and individuals may exceed these standards.

- **General Requirements:**⁵ Each specialized group home will have and maintain on file a current, written, definitive plan of operation, including a statement regarding the types of children to be served; a description of the services to be provided by the specialized group home, including admission policies and procedures regarding acceptance of children; a copy of the admission agreement; procedures for developing a needs and services plan, staffing plan, qualifications and duties; and a plan for in-service education of staff, if required by regulations governing the specific specialized group home category.
 - The specialized group home will assist with transportation arrangements for children who do not have independent arrangements.
 - The specialized group home will provide ample opportunities for family participation in activities in the specialized group home.
 - If the specialized group home intends to admit and/or specialize in care for one or more children who have a propensity for behaviors that result in harm to self or others, the plan of operation must include a description of precautions that will be taken to protect that child and all other children.
- **Intake and Assessment:**⁶ Prior to accepting a child into a specialized group home, the person responsible for admissions must interview the prospective child and his/her family and/or authorized representative, including the assigned social worker/case manager, if any, to complete the following goals and document the intake and assessment findings:
 - **Eligibility Determination:** Children eligible for specialized group home services have HIV/AIDS disease, or the diagnosis is indeterminate because of the child's age, and are in need of housing and care and supervision. A child may not be accepted for admission to a specialized group home without a completed individualized health care plan that provides contact information of the health care professional responsible for monitoring the child's ongoing health care, the appropriate number of hours of on-site supervision and monitoring, and the appropriate number of hours of off-site supervision and monitoring.
 - **Assessment:** Includes age, the assessment of health status, including HIV prevention needs, family status, family composition, special housing needs, level of independence/level of resources available to solve problems and comorbidity factors.⁷ If the specialized group home provides services for children with mental

⁵ Chapters 2 through 7 and Chapter 9, Division 6, Title 22 California Code of Regulations.

⁶ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

⁷ Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

illness, the specialized group home administrator should ensure that a written intake assessment is prepared by a licensed mental health professional prior to acceptance of the child. This assessment may be provided by a student intern if the work is supervised by a licensed mental health professional. Specialized group home administrators may utilize placement agencies, including, but not limited to, county clinics, for referrals and assessments.⁸

- **Family Education:** If a prospective child is deemed eligible for intake, the specialized group home staff should provide the child and the child's family and/or authorized representative with information about the specialized group home and its services including policies and procedures, confidentiality, safety issues, house rules, activities, rights and responsibilities, and grievance procedures. Further, child and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of children living with HIV and AIDS.⁹
- **Needs and Services Plan:** A needs and services plan must be developed for all children based upon the initial assessment. A social worker must develop the needs and services plan. (A social worker is a graduate of an accredited school of social work.¹⁰) This plan should serve as the framework for the type and duration of services provided during the child's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each child for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer children with HIV/AIDS to primary medical services and case management/social work services.
- **Contagious and Infectious Disease Management:** The child must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Children should be regularly observed and questioned about health status and symptoms that may indicate that the child has a contagious or infectious disease (other than HIV/AIDS). If a child is suspected of having a contagious or infectious disease, the child should be isolated and a physician should be consulted to determine suitability of the child's retention in the program.
- **Referral Services:** In addition to primary medical services and case management/social work services, the specialized group home should have linkages with a continuum of culturally appropriate HIV/AIDS care and services and should link and/or refer children to these service options, including, but not limited to, behavioral health/mental health services, alcohol and substance abuse services, legal

⁸ Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

⁹ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁰ Division 6, Chapter 1, Article 1, Title 22, California Code of Regulations.

and financial services.¹¹ Further, the specialized group home should provide assistance with accessing insurance benefits and entitlements. For female children of reproductive age and their families, the specialized group home will assist with referrals to obtain reproductive health care and family services. The specialized group home should also assist the child with establishing linkages with other community supports, such as recreational and adult education programs. Referrals for services should be made at any point at which the needs of the child cannot be met by the specialized group home within its established programs or services and should be documented as part of the individualized needs and services plan.

- If, during intake, it is determined that the residential support needs of the child cannot be met by the specialized group home within its programs or services, then a referral must be made to an alternate provider or venue of services.
 - If, after admission, observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral or transfer to another type of specialized group home, the specialized group home staff should consult with the child and the appropriate specialist, as necessary, to assist in determining if such needs can be met by the specialized group home within the specialized group home's programs of services or if a referral and transfer is required.
- **Support Services:**¹² Support services that are to be provided or coordinated must include but are not limited to:
 - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
 - Health related services (e.g., medication management services)
 - Transmission risk assessment and prevention counseling
 - Social services
 - Educational services
 - Recreational activities
 - Meals
 - Housekeeping and laundry
 - Transportation
 - **Discharge Planning:**¹³ Discharge planning services include, but are not limited to:
 - Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate.
 - Linkage to support services that enhance access to care (e.g. case management, meals, nutritional support, transportation)

¹¹ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

¹² Assisted Living Work Group (ALW). A Report to the US Senate Special Committee on Aging. April, 2003, p. 12.

¹³ Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White Care Act Housing Policy, U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau, with John Snow, Inc, and AIDS Housing of Washington under contract #240-96-0037, p. 22.

- Early intervention services to link HIV-positive children into care, including outreach, HIV counseling and testing, and referral.
- Housing such as permanent placement, foster care, independent housing, supportive housing, or other available housing that is age appropriate.
- **Quality Management:** The program should implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Child Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation and Quality Assessment and Management Reports.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that children of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹⁴

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Services Plan (INSP). (Goal – 100%)
2. Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING

- The Group Home must have the staff qualified to manage the specialized group home; supervise operations on a 24-hour basis; and maintain records as required by the Office of AIDS Programs and Policy (OAPP). Further, all staff should be trained

¹⁴ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

on HIV-related and confidentiality issues.¹⁵ Staff responsible for providing direct care and supervision will receive training in first-aid from persons qualified by agencies including, but not limited to, the American Red Cross. Staff responsible for providing assistance for activities of daily living need training specific to the assistance needed. Additional training requirements specified in regulation are required for child care administrators and direct care staff and must be addressed through a training plan.¹⁶ Staffing requirements include, but are not limited to:

- ***Administrative and Support Staff:***
 - A qualified administrator, with primary responsibility for the specialized group home.¹⁷
 - A qualified facility manager to be present whenever there are children present in the home; the facility manager may also have direct care responsibilities.¹⁸
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds. Support staff duties should not be assigned to child care staff unless such assignments are directly related to the care of the children and do not interfere with the performance of their child care duties.
- ***Direct Care Staff:*** All direct services to children must be provided by staff trained in the provision of specialized group home services, and all services requiring specialized skills must be performed by personnel who are licensed or certified to perform the service.¹⁹ Specialized group home personnel will be competent to provide the services necessary to meet individual child needs and will, at all times, be employed in numbers necessary to meet such needs. Direct care staffing requirements include:
 - Social work staff to develop an individual needs plan (this position may be available through the County or other resources).
 - At least one facility/group home manager must be present at all times when children are present.
 - At least one staff person to provide care and supervision to no more than ten children from 7:00 a.m. to 10:00 p.m. For children requiring specialized in-home health care, there must be one staff person for every 3 children.
 - For night supervision from 10:00 p.m. to 7:00 a.m., direct care staff must include:
 - Group Homes with 12 or fewer children: one child care staff person on duty;
 - Group Homes with 13 to 30 children: one child care staff person awake and on duty, and another person on call and capable of arriving at the group home site within 30 minutes;

¹⁵ P.A.T.H., People Assisting the Homeless contract with the County of Los Angeles, February 26, 2002.

¹⁶ Chapter 5, Article 6, Section 84064, Title 22, California Code of Regulations.

¹⁷ Chapter 5, Article 6, Section 84064, Title 22, California Code of Regulations.

¹⁸ Chapter 5, Article 6, Section 84065, Title 22, California Code of Regulations.

¹⁹ Chapter 5, Article 6, Section 84065, Title 22, California Code of Regulations.

- Group Homes with 31 or more children: one child care staff person awake and on duty for the first 30 children; and one child care staff person awake and on duty for each additional 30 children or fraction of that amount; and
- In facilities with a licensed capacity of 13 or more children, one employee must be designated by the administrator to have primary responsibility for planned activities and must be given assistance as necessary to ensure that all children participate in accordance with their needs, interests and abilities.
- At least monthly consultation from a psychiatrist or clinical psychologist or licensed clinical social worker regarding the program of services for children diagnosed as mentally disordered.
- At least monthly consultation by a qualified mental retardation specialist for children diagnosed with developmental disabilities.
- Children may not be used as substitutes for required staff but may be permitted, as a voluntary part of their program of activities, to participate in household duties and other tasks suited to the child's needs and abilities.

LENGTH OF STAY

Indeterminate — until the child no longer meets criteria.

SERVICES

- ***Development of the Needs and Services Plan:*** A social worker develops, with the child, family and/or authorized representative, the Needs and Services Plan. The Needs and Services Plan should include the child's background, including medical and mental/emotional functioning and the specialized group home's plans for providing services to meet the individual needs identified above. If the child has a restricted health condition, the Needs and Services Plan must include a Restricted Health Condition Care Plan.
- ***Review/Reevaluation of the Needs and Services Plan:*** The Plan should be updated as frequently as necessary and at least every six months to ensure its accuracy and to document significant occurrences that result in changes in the child's physical, mental, and/or social functioning. If modifications to the plan identify an individual child's service need which is not being met by the specialized group home, the specialized group home must secure consultation to determine if the specialized group home can meet the child's service need. If it is determined that the child's needs cannot be met, the specialized group home should assist with relocation of the child into an appropriate level of care.
- ***Implementation of the Needs and Services Plan:*** Services identified in the Needs and Services Plan should be provided directly, or the specialized group home should link the child with outside resources.

- ***Coordination of Medical/Dental Services:*** The specialized group home will ensure that every child receives necessary first-aid and other medical and dental needs, including arrangement for and/or provision of transportation to the nearest available services.
- ***Administration of Medication:*** Children will be assisted with administration of prescription and non-prescription medications.
- ***Personal Assistance and Care:*** The specialized group home will provide necessary personal assistance and care, as indicated in the Needs and Services Plan, with activities of daily living including, but not limited to, dressing, eating, and bathing.
- ***Support and Recreational Services:*** The specialized group home will provide basic laundry services, including washing and drying of the child's personal clothing. The specialized group home will ensure that planned recreational activities are provided for the children. Each child who is capable will be given the opportunity to participate in the planning, preparation, conducting, clean-up, and critiquing of the activities. The specialized group home will ensure that children are given the opportunity to attend and participate in community activities including, but not limited to, the following:
 - worship services and activities of the child's choice;
 - community service activities;
 - community events including, but not limited to, school events, concerts, tours, dances, play, and celebrations of special events;
 - self-help organizations; and
 - other age-appropriate activities, such as playgrounds.

MEDI-CAL COVERAGE

Group home is not a covered Medi-Cal service; however, some services, such as physician services, provided at the group home may be covered under the Medi-Cal state plan. The Department of Children and Family Services is the primary funding source for the Group Homes contracted with OAPP.

**Department of Health Services
Office of AIDS Policy and Programs**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service definition adopted by the County of Los Angeles Department of Health Services/Office of AIDS Policy and Programs. This definition is intended to guide providers in the development and implementation of services to individuals at-risk for or living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Residential Transitional Housing

LICENSURE CATEGORY

Residential Transitional Housing may be licensed as facilities operating an adult residential facility, a community care facility, or a congregate living facility which offer residential transitional housing.

DEFINITIONS AND DESCRIPTIONS

“Transitional Housing” means housing with supportive services for up to four months that are exclusively designated and targeted for recently homeless persons.

“HIV/AIDS residential transitional housing” is interim housing for homeless persons with HIV disease or AIDS. The purpose of these housing services is to facilitate movement towards more traditional and permanent housing through assessment of the individual’s needs, counseling, and case management.

“Homeless” persons are defined as individuals with HIV-disease or AIDS who lack a fixed, regular, and adequate residence or reside in: 1) a shelter designed to provide temporary, emergency living accommodations; 2) an institution that provides a temporary residence for individuals intended to be institutionalized; or 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.¹

¹County of Los Angeles contract, Residential Transitional Housing Service Agreement, February 26, 2002.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined.² In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS.³ Clients with HIV/AIDS in transitional housing settings require special attention particularly in relation to the coordination of a continuum of services including medical, psychological and social support services while residing in the facility. Additionally, risk assessment, transmission prevention and treatment adherence are important concerns that impact the health and quality of life of both HIV positive and HIV negative residents in the facility.

PROGRAM REQUIREMENTS

General Requirements: HIV/AIDS residential transitional housing services are provided to persons who are homeless and who have HIV disease or AIDS.⁴

For licensed facilities operating an adult residential facility, a community care facility, a transitional housing facility, or a congregate living facility which offer residential transitional housing, general program requirements are established in standards describing that service.

- For residential transitional housing services which are not licensed, requirements include:⁵
 - Each facility will have and maintain on file a current, written, definitive plan of operation including, admission policies and procedures regarding acceptance of clients, a copy of the admission agreement, staffing plan, qualifications and duties, and a plan for in-service education of staff, if required by regulations governing the specific facility category.
 - The facility will assist with transportation arrangements for clients who do not have independent arrangements.
 - The facility will provide ample opportunities for family participation in activities in the facility.
 - If the facility intends to admit and/or specialize in care for one or more clients who have a propensity for behaviors that result in harm to self or others, the plan of operation will include a description of precautions that will be taken to protect that client and all other clients.
- **Intake and Assessment:**⁶ Prior to accepting a client into transitional housing services, the person responsible for admissions must interview the prospective client and

² AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

³ Presentation Materials - Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁴ Excerpted from P.A.T.H. People Assisting the Homeless contract with the County of Los Angeles, February 26, 2002.

⁵ Excerpted from Chapters 2 through 7 and Chapter 9, Division 6, Title 22 California Code of Regulations.

⁶ Source: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, and 1531, Health and Safety Code.

his/her authorized representative, including the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:

- **Eligibility Determination:** Persons eligible for transitional housing have HIV/AIDS disease and are in need of housing. At the minimum determination of eligibility should be based on housing status and financial eligibility. HIV status should also be documented during the intake process.
 - **Assessment:** Includes age, the assessment of health status, including HIV prevention needs, family status, family composition, special housing needs, level of independence/level of resources available to solve problems and comorbidity factors.⁷ The focus of the assessment is on transitioning the person to stable housing.
 - **Resident Education:** If a client is deemed eligible for intake, the facility staff should provide the prospective client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures. Further, resident education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS.⁸
- **Needs and Services Plan:** A needs and services plan must be developed for all clients prior to admission based upon the initial assessment.⁹ The focus of this plan is on referral to appropriate permanent housing, case management, and medical services.
 - **Contagious and Infectious Disease Management:** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. The nature of transitional housing may preclude having important information prior to admission of the client. However, whenever possible, the client must be observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
 - **Referral Services:** In addition to primary medical services and case management, the facility should have linkages to a continuum of culturally appropriate HIV/AIDS care and services and should link and/or refer clients to these service options, including but not limited to, behavioral health/mental health services, alcohol and substance

⁷ Greater Baltimore HIV Health Services Planning Council, HIV Standards of Care, 1999.

⁸ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

⁹ Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, and 1531, Health and Safety Code.

abuse services, legal and financial services.¹⁰ Further, the facility should provide assistance with accessing insurance benefits and entitlements.

- **Support Services:**¹¹ Support services that are to be provided or coordinated must include but are not limited to:
 - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
 - Health related services (e.g., medication management services)
 - Transmission risk assessment and prevention counseling
 - Social services
 - Recreational activities
 - Meals
 - Housekeeping and laundry
 - Transportation
- **Discharge Planning:**¹² Discharge planning services include, but are not limited to:
 - Linkage to primary medical care, emergency assistance, supportive services and early intervention services as appropriate.
 - Linkage to support services that enhance access to care (e.g. case management, meals, nutritional support, transportation)
 - Early intervention services to link HIV-positive people into care, including outreach, HIV counseling and testing, and referral.
 - Housing such as permanent housing, independent housing, supportive housing, or other available housing.
- **Quality Management:** The program should implement an annual Quality Management (QM) Plan in accordance with contract requirements that addresses goals pertaining to the following components: QM Committee, Written Policies & Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation and Quality Assessment and Management Reports.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.¹³

¹⁰ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

¹¹ Assisted Living Work Group (ALW). A Report to the US Senate Special Committee on Aging. April, 2003, p. 12.

¹² Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau Ryan White Care Act Housing Policy, U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau, with John Snow, Inc, and AIDS Housing of Washington under contract #240-96-0037.p. 22.

¹³ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

PROCESS AND OUTCOME INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an Individual Needs and Services Plan (INSP). (Goal – 100%)
2. Establish baseline and perform on-going monitoring of the percent of HIV/AIDS residents that participate in a medical office visit and evaluation at least quarterly. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with their living situation and services received through the residential program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the INSP. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING

The Transitional Housing Facility must have the staff qualified to manage the facility, supervise operations on a 24-hour basis, and maintain records as required by the Office of AIDS Programs and Policy (OAPP). Further, all staff should be trained on HIV-related and confidentiality issues.¹⁴ For licensed facilities operating an adult residential facility, a community care facility, or a congregate living facility which offer residential transitional housing, staffing requirements are established in regulations describing those services. For programs that do not fall into these licensure categories but provide transitional housing services, the staffing requirements include, but are not limited to:

- **Administrative and Support Staff:**
 - An employee, with primary responsibility for the facility
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds
- **Direct Care Staff:** The facility will ensure that all direct services to clients are provided by staff trained in the provision of facility services and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.

For daytime support, direct care staff must include:

- Employee(s) designated to perform admission, intake and assessment functions, including ongoing evaluation of the residents' supervision and care needs.

¹⁴ P.A.T.H. People Assisting the Homeless contract with the County of Los Angeles, February 26, 2002.

- An employee responsible for oversight and provision of planned activities, including oversight of volunteers. For facilities with a licensed capacity of 16 to 49 clients, the person responsible for planned activities may have other responsibilities; for facilities with a licensed capacity of 50 or more clients, the designated activities employee must be full time.
- Staff ratio of no less than 1 direct care staff to 3 clients for residents who require staff assistance to perform all activities of daily living.

For night supervision from 10:00 p.m. to 7:00 a.m., direct care staff must include:

- Facilities housing 15 or fewer clients – 1 staff person on call and on the premises;
- Facilities housing 16 to 100 clients – 1 staff person on duty, awake and on the premises;
- Facilities housing 101 to 200 clients – at least 1 staff person on duty, on the premises and awake, and at least 1 staff person on-call, on the premises, and another person on-call and capable of responding within 30 minutes;
- Facilities housing 7 or more clients who rely upon others to perform all activities of daily living – at least 1 person on duty, on the premises, and awake at night; for every additional 14 such clients – 1 additional person on duty, on the premises, and awake at night.

LENGTH OF STAY

The length of stay varies, but is limited to four months. Residential transitional housing is offered until the client transitions to a more independent living environment.¹⁵ Any extensions beyond the four month length of stay require prior approval from OAPP.

SERVICES

Transition housing facilities provide the following services:

- Lodging in a secured facility with individual rooms that are clean, safe, comfortable, and alcohol and drug free.
- Making available for residents to prepare, have delivered, or be referred for at least two balanced and complete meals per day (referrals to missions or soup kitchens are not acceptable alternatives).
- Adequate heating and lighting, plumbing, hot and cold water, toiletries, and bathing facilities.
- Accessible telephone in working condition, available for clients to make local phone calls that are job, family, or housing related.
- Self-sufficiency development services, with the ultimate goal of moving recently homeless persons to permanent housing as quickly as possible.
- Support services including referrals to case management, medical, and social services.

¹⁵ HIV/AIDS and Substance Use Standards of Care, County of Los Angeles Commission on HIV Health Services, 1999 and A Summary Report on California's Programs to Address Homelessness. Prepared for Governor Gray Davis, March, 2002, page 33.

MEDI-CAL COVERAGE

Transitional residential facility is not a covered Medi-Cal service; however, some services, such as physician services, provided at the facility may be covered under the Medi-Cal state plan.

**Department of Health Services
Office of AIDS Programs and Policy**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County of Los Angeles Department of Health Services, Office of AIDS Programs and Policy. This description is intended to guide providers in the development and implementation of services to individuals living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Substance Abuse Day Treatment

LICENSURE CATEGORY

Certification Category — Outpatient Day Care Habilitative

DEFINITIONS AND DESCRIPTIONS

“Substance Abuse Day Treatment”, also known as outpatient day care habilitative services, means a nonresidential therapeutic service providing a minimum of five hours of planned activities per day, with clients attending at least three days per week. Planned activities include intake, assessment, individual service planning, crisis intervention, individual, group and family counseling, support groups, weekly case conference, and referral to other agencies for medical, HIV/AIDS case management, social, psychological, vocational, educational, legal, health education, or other support services deemed appropriate. The purpose of this service is to provide a planned program in a structured setting to maximize the rehabilitation of clients. Such programs are designed to provide services more intensive than an outpatient visit but less extensive than 24-hour residential. At a minimum, services should be offered at least five hours per day, five days per week of individual or group sessions and/or structured therapeutic activities.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam and the Persian Gulf combined¹. In the County of Los Angeles, it is estimated that more

¹ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

than 53,000 people are living with HIV/AIDS². Intravenous drug use is second only to intercourse with an HIV-positive man as the most common method of infection³. Existing performance standards for the delivery of care typically target either HIV or substance use, but rarely address the integration of these two services. HIV-positive substance abusers have a wide spectrum of health care needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, services such as primary care, substance abuse treatment, mental health treatment, and support services should be integrated and easily accessible. Research has demonstrated that coordination of care, particularly for clients accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved health outcomes⁴.

PROGRAM REQUIREMENTS

The following are minimum requirements for substance abuse day treatment programs. Programs may exceed these requirements.

- **General requirements:** The program must ensure its ability to meet the needs of the client by meeting the following general requirements:
 - Substance Abuse Day Treatment Programs must operate in accordance with Chapter 5, Division 4, Title 9 of the California Code of Regulations.
 - For individuals in substance abuse day treatment programs who are HIV/AIDS infected, regular on-going transmission assessments should be performed.
 - For individuals in substance abuse day treatment programs who are assessed as “ready” for additional HIV/AIDS information, transmission risk and infection risk education should be provided. Programs assessing readiness are encouraged to use Prochaska's Transtheoretical Model of Personal Change⁵, which identifies six stages of personal change, including precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska et al. maintains that individuals move through predictable stages of change as they endeavor to overcome problem behaviors.
- **Intake and Assessment:** Prior to accepting a client into a substance abuse day treatment program, the person responsible for admissions must interview the prospective client and his/her authorized representative, if any, to document the following:
 - **Eligibility Determination:** Persons eligible for substance abuse day treatment services must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance dependence and meet the following criteria⁶:
 - Withdrawal Potential — minimal withdrawal risk;

² Presentation Materials - Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

³ Information published on County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁴ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

⁵ Prochaska's Transtheoretical Model of Personal Change (Prochaska, Norcross & DiClemente, 1994).

⁶ American Society of Addiction Medicine Patient Placement Criteria.

- Biomedical Conditions — none that interfere with addiction treatment;
 - Emotional/Behavioral Conditions — mild severity with potential to distract from recovery;
 - Treatment Acceptance/Resistance — resistance high enough to require structured program, but not so high as to render outpatient treatment ineffective;
 - Relapse Potential — likelihood of relapse without close monitoring and support; and
 - Recovery Environment — unsupportive environment but with structure and support, the client can cope.
- *Assessment:* The assessment process should include utilization of the Addiction Severity Index.

The assessment should provide the information required to recommend the most appropriate course of treatment. Areas that should be investigated in the assessment include⁷:

- archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records;
- patterns of alcohol and drug (AOD) use;
- impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;
- risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;
- available health and medical findings, including emergency medical needs;
- psychological test findings;
- educational and vocational background;
- suicide, health, or other crisis risk appraisal;
- client motivation and readiness for treatment;
- client attitudes and behavior during assessment; and
- client HIV risk behaviors and factors.

In addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor should coordinate with the client's medical care provider to ascertain information regarding⁸:

- medical history,
- results of a physical examination, and
- results of laboratory tests and follow-up required.

⁷ Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

⁸ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- **Client Education:** Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS⁹.
- **Treatment Plan:** A treatment plan must be developed for all clients based upon the initial assessment. This plan should serve as the framework for type and duration of services provided during the client's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.

The client must sign an admission agreement authorizing treatment within three days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include:¹⁰

- an interim treatment plan which identifies the client's immediate treatment needs must be developed within three days from the date of admission;
 - within 14 days from the date of admission, the counselor must develop a comprehensive treatment plan with long and short term goals for the continuing treatment needs of each client;
 - treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified;
 - the treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs;
 - treatment plan goals and objectives must be broken down into manageable, measurable units;
 - the treatment plan must be reviewed and re-evaluated 28 days after development and every 90 days thereafter or more often, if needed, as the client completes each phase of treatment; and
 - each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.
- **Referral Services:** In addition to primary medical services and case management, the program must be linked to a continuum of HIV/AIDS care and services and must link

⁹ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁰ Excerpted from Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft; Low Intensity Residential Services.

and/or refer clients to these service options including, but not limited to mental health, medical care, and legal and financial services¹¹. Referrals for services should be made at any point at which the needs of the client cannot be met by the program within its established range of services. In addition:

- if during intake it is determined that the needs of the client cannot be met by the program within the program's range of services, then a referral must be made to an alternate provider or venue of services; and
 - If after admission, observation, or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral, or transfer to another type of program, the program staff must consult with the appropriate specialist(s), as necessary, to assist in determining if such can be met by the program within the program's range of services or if a referral and transfer is required.
- ***Contagious/Infectious Disease Prevention and Intervention:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
 - ***Support Services and Discharge Planning:*** Support services that are to be provided or coordinated must include, but are not limited to:
 - provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living),
 - health related services (e.g., medication management services),
 - transmission risk assessment and prevention counseling,
 - social services,
 - recreational activities,
 - meals,
 - housekeeping and laundry,
 - transportation, and/or
 - housing.

Discharge planning should include a written aftercare plan that includes specific substance abuse treatment recommendations utilizing different modalities and approaches. Clients should be offered the opportunity to participate in the aftercare planning process and should receive a copy of the plan including active referrals to appropriate services. Clients should leave knowing they are welcome to contact the program at any time. Programs should maintain contact with clients post-discharge¹².

¹¹ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

¹² Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

- **Quality Management:** The program should implement an annual Quality Management (QM) Plan that addresses the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports. The program must comply with contractual requirements related to QM.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency¹³.

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an individual treatment plan. (Goal – 100%)
2. Establish baseline and perform ongoing monitoring of the percent of clients who have had at least one medical care consultation during the substance abuse treatment episode.
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with the services received through the program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the treatment plan. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING¹⁴

The Substance Abuse Day Treatment program must have the following staff:

- **Administrative and Support Staff:**
 - a program administrator or designee must be on-site or able to return telephone calls within one and one-half hours and able to appear in person within three hours;

¹³ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹⁴ Adapted from Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft, Low Level Intensity Residential Substance Abuse Services and Mercer Government Human Services Consulting Best Practices Review.

- a Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (MFT), licensed clinical psychologist, or licensed physician to supervise program operations staff and provide required professional expertise when appropriate, and
- support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- **Direct Care Staff:** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - a counselor designated to perform admission, intake, and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - a counselor responsible for oversight and provision of planned activities, including oversight of volunteers; and
 - the program should provide a staffing ratio of not less than one counselor for every 12 clients enrolled in the program. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction.

LENGTH OF STAY

Not to exceed 90 days, although an extension can be made as long as the client meets continuing stay criteria in accordance with American Society of Addiction Medicine.

SERVICES

- The program must identify a schedule of activities that promotes sustained recovery.
- The schedule must include both individual and group activities for a minimum of five hours per day, five days per week that focus on:
 - abstinence and relapse prevention;
 - physical health and well-being;
 - practical life skills including the ability to be self-supporting;
 - improved personal functioning, and effective coping with life problems;
 - social functioning, including improved relationships with family, socially acceptable ethics, and enhanced communication and interpersonal relationship skills;
 - improving the individual's self-image, esteem, confidence, insight, understanding, and awareness; and
 - additional life skills such as communication, finance management, hygiene, training in leisure activity development, homemaking and parenting skills, stress and anger management, and physical fitness.
- Substance Abuse Day Treatment services include¹⁵:

¹⁵ County of Los Angeles Contract, Additional Provisions, February 26, 2002.

- intake;
- assessment;
- individual service planning;
- crisis intervention;
- individual, group, and family counseling;
- support groups;
- weekly case conference; and
- referral to other agencies for medical, HIV/AIDS case management, social, psychological, vocational, educational, legal, health education, or other support services deemed appropriate for contributing to the client's rehabilitation.
- The program should actively engage clients in treatment with an emphasis on¹⁶:
 - interventions, activities, or service elements uniquely designed to alleviate or preclude alcohol and/or other drug problems in the individual, their family, and/or the community;
 - the goals of physical health and well-being, practical life skills, including the ability to be self-supporting, improved personal functioning, and effective coping with life problems;
 - social functioning, including improved relationships with family, socially acceptable ethics, and enhanced communication and interpersonal relationship skills;
 - improving the individual's self-image, esteem, confidence, insight, understanding, and awareness; and
 - additional life skills such as communication, finance management, hygiene, training in leisure, homemaking and parenting skills, stress, relaxation and anger management, physical fitness, and field trips.
- The program must ensure that, to the maximum extent possible, the program staff provides information regarding community resources and their utilization. The program must maintain and make available to clients a current list of resources within the community that offer services that are not provided within the program. At a minimum, the list of resources includes medical, dental, mental health, public health, social services, and where to apply for the determination of eligibility for state, federal, or county entitlement programs.
- Referrals should be made to these outside resources, as appropriate.
- Each program must provide services including counseling sessions to clients, as reflected in the client's treatment plan.

MEDI-CAL COVERAGE

This service is not a Drug Medi-Cal covered service, except for perinatal women or women in the postpartum period, and/or to Early and Periodic Screening Diagnosis and Treatment (EPSDT)-eligible beneficiaries¹⁷.

¹⁶ Excerpted from Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft; Low Intensity Residential Services.

¹⁷ Title 22, California Code of Regulations. Division 3, Subdivision 1, Chapter 3, Article 4, §51341.1(b)(6).

**Department of Health Services
Office of AIDS Program and Policies**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County Los Angeles Department of Health Services/Office of AIDS Programs and Policy. This description is intended to guide providers of services in the development and implementation of services to individuals living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Substance Abuse Methadone Maintenance

LICENSURE CATEGORY

Narcotic Treatment Program

DEFINITIONS AND DESCRIPTIONS

“Narcotic Treatment Program” means any opiate addiction treatment modality, whether inpatient or outpatient, which offers replacement narcotic therapy in maintenance, detoxification, or other services, in conjunction with that replacement narcotic therapy¹.

“Narcotic Treatment Program” means an outpatient service using methadone, directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance abuse diagnosis².

“Maintenance Treatment” means the treatment modality whereby replacement narcotic therapy is used in sustained, stable, medically-determined dosage levels for a period in excess of 21 days, to reduce or eliminate chronic opiate addiction, while the client is provided a comprehensive range of treatment services³.

¹ Chapter 4, Division 4, Title 9, of the California Code of Regulations.

² Chapter 3, Division 3, Title 22 (Drug Medi-Cal), of the California Code of Regulations.

³ Chapter 4, Division 4, Title 9, of the California Code of Regulations.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam, and the Persian Gulf combined⁴. In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS⁵. Intravenous drug use is second only to intercourse with an HIV-positive man as the most common method of infection⁶. Existing performance standards for the delivery of care typically target either HIV or substance use, but rarely addresses the integration of these two services. HIV-positive substance abusers have a wide spectrum of health care needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, services such as primary care, substance abuse treatment, mental health treatment, and support services should be integrated and easily accessible. Research has demonstrated that coordination of care, particularly for clients accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved health outcomes⁷.

Opioid substitution therapy has been proposed as the preferred method of treatment of HIV-infected opioid users because it frequently involves daily attendance at a clinic that may offer access to medical care, psychiatric consultation and treatment, neuropsychological evaluation, and social services. Studies have demonstrated that opioid substitution therapy is associated with a reduced risk of contracting HIV and may prevent infection of those patients not yet exposed to the virus⁸. Medications (methadone) can be used by HIV-infected substance abusers in the same way they are used by uninfected clients. Neither maintenance nor detoxification treatment need be altered by the presence of HIV infection. However, treating the individual with HIV/AIDS in a Narcotic Treatment Program does require specialty expertise and knowledge of drug interactions between methadone/other maintenance drugs and HIV/AIDS⁹.

PROGRAM REQUIREMENTS

The following are minimum requirements for substance abuse methadone maintenance programs. Programs may exceed these requirements.

- **General Requirements:** The program must ensure its ability to meet the needs of the client by meeting the following general requirements:
 - Substance abuse narcotic treatment programs must be licensed by the Department of Alcohol and Drug Programs.
 - Substance abuse narcotic treatment programs must operate in accordance with Chapter 4, Division 4, Title 9 of the California Code of Regulations.

⁴ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁵ Presentation Materials — Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁶ Information published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁷ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

⁸ Treatment Improvement Protocol #37, Substance Abuse Treatment for Persons with HIV/AIDS, Center for Substance Abuse Treatment.

⁹ Treatment Improvement Protocol #37, Substance Abuse Treatment for Persons with HIV/AIDS, Center for Substance Abuse Treatment.

- For individuals in substance abuse methadone maintenance programs who are HIV/AIDS infected, regular on-going transmission assessments should be performed.
 - For individuals in substance abuse methadone maintenance programs who are assessed as “ready” for additional HIV/AIDS information, transmission risk and infection risk education should be provided. Programs assessing readiness are encouraged to use Prochaska's Transtheoretical Model of Personal Change¹⁰, which identifies six stages of personal change, including precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska et al. maintains that individuals move through predictable stages of change as they endeavor to overcome problem behaviors.
- ***Intake and Assessment:*** Prior to accepting a client into a substance abuse methadone maintenance program, the person responsible for admissions must interview the prospective client and his/her authorized representative, if any, to document the following:
 - ***Eligibility Determination:*** The program determines which applicants with an addiction to opiates are accepted as patients for maintenance treatment subject to the following minimum criteria which is to be entered in the client records¹¹:
 - Confirmed documented history of at least two years of addiction to opiates. The method to be used to make confirmations must be stated in the program's protocol. The program must maintain in the client record documents, such as records of arrest or treatment failures, which are used to confirm two years of addiction to opiates. Statements from personal friends or family are not sufficient to establish a history of addiction. With prior California Department of Alcohol and Drug Program approval, the program may make an exception to this requirement only if the program physician determines, based on his or her medical training and expertise, that withholding treatment constitutes a life- or health-endangering situation. The program physician must document the reason for this determination in the client record.
 - Confirmed history of two or more unsuccessful attempts in withdrawal treatment with subsequent relapse to illicit opiate use. The methods used to make confirmations and the types of documentation to be maintained in the client's record must be stated in the program's protocol. At least seven days must have elapsed since completion of the immediately preceding episode of withdrawal treatment.
 - Must be a minimum age of 18 years old.
 - Certification by a physician of fitness for replacement narcotic therapy based upon physical examination, medical history, and indicated laboratory findings. Plans for correction of existing medical problems should be indicated.
 - Evidence of observed signs of physical dependence.
 - In addition to these criteria, the following conditions are provided:

¹⁰ Prochaska's Transtheoretical Model of Personal Change (Prochaska, Norcross & DiClemente, 1994).

¹¹ Title 9, Division 4, Article 3, California Code of Regulations.

- An applicant who has resided in a penal or chronic care institution for one month or longer may be admitted to maintenance treatment within one month of release without documented evidence to support findings of physical dependence, provided the person would have been eligible for admission before he or she was incarcerated or institutionalized and, in the clinical judgment of the medical director or program, treatment is medically justified.
- Previously treated patients who voluntarily detoxified from maintenance treatment may be admitted to maintenance treatment without documentation of current physical dependence within six months after discharge, if the program is able to document prior maintenance treatment of six months or more and, in the clinical judgment of the medical director or program physician, treatment is medically justified. Patients admitted pursuant to this subsection may, at the discretion of the medical director or program physician, be granted the same take-home step level they were on at the time of discharge.
- Pregnant clients who are currently physically dependent on opiates and have had a documented history of addition to opiates in the past may be admitted to maintenance treatment without documentation of a two-year addiction history or two prior treatment failures, provided the medical director or program physician, in his or her clinical judgment, finds treatment to be medically justified.

➤ *Assessment:* The assessment process should include utilization of the Addiction Severity Index.

The assessment process should include a broad variety of components that will yield an evaluation of the client that is as comprehensive and holistic as possible. The assessment should provide the information required to recommend the most appropriate course of treatment. Areas that should be investigated in the assessment include¹²:

- archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records;
- patterns of alcohol and drug (AOD) use;
- impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;
- risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;
- available health and medical findings, including emergency medical needs;
- psychological test findings;
- educational and vocational background;
- suicide, health, or other crisis risk appraisal;
- client motivation and readiness for treatment;

¹² Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

- client attitudes and behavior during assessment; and
- client HIV risk behaviors and factors.

In addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor should coordinate with the client's medical care provider to ascertain information regarding¹³:

- medical history,
- results of a physical examination, and
- results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- *Client Education:* Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS¹⁴.
- **Treatment Plan:** A treatment plan must be developed for all clients based upon the initial assessment. This treatment plan should serve as the framework for type and duration of services provided during the client's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.

The client must sign an admission agreement authorizing treatment within three days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include¹⁵:

- an interim treatment plan which identifies the client's immediate treatment needs must be developed within three days from the date of admission;
- within 28 days from the date of admission, the counselor must develop a comprehensive treatment plan with long- and short-term goals for the continuing treatment needs of each client;
- a physician must sign the treatment plan within 15 days after the counselor has developed and signed the treatment plan;
- treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified;

¹³ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹⁴ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁵ Title 9, Division 4, Article 3, California Code of Regulations.

- the treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs;
 - treatment plan goals and objectives must be broken down into manageable, measurable units;
 - the treatment plan must be reviewed and re-evaluated at least every 90 days or more often, if needed, as the client completes each phase of treatment; and
 - each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.
- ***Referral Services:*** In addition to primary medical services and case management, the program must be linked to a continuum of HIV/AIDS care and services and must link and/or refer clients to these service options, including, but not limited to, mental health, medical care, legal, and financial services¹⁶. Referrals for services should be made at any point at which the needs of the client cannot be met by the program within its established range of services. In addition:
 - if during intake it is determined that the needs of the client cannot be met by the program within the program's range of services, then a referral must be made to an alternate provider or venue of services; and
 - if after admission observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral, or transfer to another type of program, the program staff must consult with the appropriate specialist(s), as necessary, to assist in determining if such can be met by the program within the program's range of services or if a referral and transfer is required.
 - ***Contagious/Infectious Disease Prevention and Intervention:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
 - ***Support Services and Discharge Planning:*** Support services that are to be provided or coordinated must include, but are not limited to:
 - provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living),
 - health-related services (e.g., medication management services),
 - transmission risk assessment and prevention counseling,
 - social services,
 - recreational activities,
 - meals,
 - housekeeping and laundry,

¹⁶ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

- transportation, and/or
- housing.

Discharge planning should include a written aftercare plan that includes specific substance abuse treatment recommendations utilizing different modalities and approaches. Clients should be offered the opportunity to participate in the aftercare planning process and should receive a copy of the plan, including active referrals to appropriate services. Clients should leave knowing they are welcome to contact the program at any time. Programs should maintain contact with clients post-discharge¹⁷.

- **Quality Management:** The program should implement an annual Quality Management (QM) Plan that addresses the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports. The program must comply with contractual requirements related to QM.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency¹⁸.

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an individual treatment plan. (Goal – 100%)
2. Establish baseline and perform ongoing monitoring of the percent of clients who have had at least one medical care consultation during the substance abuse treatment episode. (Goal – 100%)
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with the services received through the program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the treatment plan. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

¹⁷ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁸ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

REQUIRED STAFFING¹⁹

The Substance Abuse Methadone Maintenance program must have the following staff:

- ***Administrative and Support Staff:***
 - Each program must have a medical director who is a licensed physician in the State of California. The medical director may also serve as the program director. The medical director assumes the medical responsibility for all program patients by:
 - signing client record notes;
 - placing clients in treatment;
 - initiating, altering, and terminating replacement narcotic therapy medications and dosage amounts;
 - supervising the administration and dispensing of medications;
 - planning and supervising provision of treatment, including regular review and notes in the patients' records; and
 - the medical director may delegate duties as prescribed in the program protocol to another licensed program physician(s), but may not delegate his/her responsibility to physician extenders (i.e., physician assistants or nurse practitioners).
 - Each program must have a program director who is responsible for submitting protocols and reports, operating the program, complying with regulations, training and supervising staff, notifying all clients of their obligations to safeguard take-home medications, and security of client records and medications.
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- ***Direct Care Staff:*** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - a counselor designated to perform admission, intake and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - a counselor responsible for oversight and provision of planned activities, including oversight of volunteers;
 - appropriately licensed personnel under the program physician's direction to administer or dispense medications to clients;
 - a medical director or medical designee who should see the client face-to-face at least once every three months; and
 - a staffing ratio of not less than one counselor for every 40 clients enrolled in the program. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with narcotic addiction and treatment.

¹⁹ Chapter 3, Division 3, Title 22 (Drug Medi-Cal), of the California Code of Regulations.

LENGTH OF STAY

As long as the client meets continuing stay criteria.

Note: CSAT TIP 1, State Methadone Treatment Guidelines: “How long should methadone maintenance treatment last? As long as it needs to, or simply, long enough. Treatment should be continued as long as the client continues to benefit from treatment, wishes to remain in treatment, remains at risk of relapse to heroin or other substance use, suffers no significant adverse effects from continued methadone maintenance treatment, and as long as continued treatment is indicated in the professional judgment of the physician.”²⁰

SERVICES

- Narcotic treatment program services, utilizing methadone as narcotic replacement drugs, include²¹:
 - intake,
 - treatment planning,
 - medical direction,
 - body specimen screening, including a urinalysis screening at admission and at least monthly thereafter,
 - physician and nursing services related to substance abuse,
 - medical psychotherapy,
 - a minimum of one 50-minute individual counseling session per month,
 - group counseling,
 - admission physical examinations and laboratory tests,
 - medication services, and
 - the provision of methadone, as prescribed by a physician to alleviate the symptoms of withdrawal from opiates.

MEDI-CAL COVERAGE

This service is a Drug Medi-Cal covered service.

²⁰ Treatment Improvement Protocol #1, State Methadone Treatment Guidelines, Center for Substance Abuse Treatment.

²¹ Chapter 3, Division 3, Title 22 (Drug Medi-Cal), of the California Code of Regulations.

**Department of Health Services
Office of AIDS Programs and Policy**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County of Los Angeles Department of Health Services/Office of AIDS Programs and Policy. This description is intended to guide providers of services in the development and implementation of services to individuals living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Substance Abuse Residential Detoxification

LICENSURE CATEGORY

Chemical Dependency Recovery Hospital or Acute Psychiatric Facility

DEFINITIONS AND DESCRIPTIONS

“Detoxification” means that process whereby the body rids itself of noxious or intoxicating chemicals. Detoxification services are those practices and/or procedures by which others manage or try to control the individual's withdrawal syndrome.¹

“Medical detoxification” means the administration of any medication for the specific purpose of managing and/or preventing withdrawal syndrome.²

“HIV/AIDS” substance abuse residential detoxification services medically assist a person suffering from chemical dependency in the process of physiological removal of the noxious or intoxicating chemicals on which he or she is dependent. These services shall be provided within a facility licensed and approved by the State of California Department of Health Services as a Chemical Dependency Recovery Hospital, in accordance with current federal and state standards for such facilities.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam, and the Persian Gulf combined³. In the County of Los Angeles, it is estimated that more

¹ Title 22, Chapter 11.

² Ibid.

³ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

than 53,000 people are living with HIV/AIDS⁴. Intravenous drug use is second only to intercourse with an HIV-positive man as the most common method of infection⁵. Existing performance standards for the delivery of care typically target either HIV or substance use, but rarely addresses the integration of these two services. HIV-positive substance abusers have a wide spectrum of health care needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, services such as primary care, substance abuse treatment, mental health treatment, and support services should be integrated and easily accessible. Research has demonstrated that coordination of care, particularly for clients accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved health outcomes⁶.

PROGRAM REQUIREMENTS

The following are minimum requirements for substance abuse residential detoxification programs. Programs may exceed these requirements.

- **General Requirements:** The program must ensure its ability to meet the needs of the client by meeting the following general requirements:
 - Substance abuse residential detoxification programs must be licensed by Community Care Licensing.
 - Residential detoxification programs must operate in accordance with Chapter 11, Title 22 of the California Code of Regulations.
 - Residential detoxification services are appropriate for individuals that, after assessment, are identified as requiring medical management or medical monitoring for the management of withdrawal, and require this level of service to complete detoxification and enter into continued treatment.
 - When a program admits an individual solely for detoxification services, the program must ensure that:
 - the health questionnaire is completed as soon as possible within the first 36 hours of admission,
 - the admission agreement is completed and signed within 36 hours of admission, and
 - if the client leaves prior to the completion of a health questionnaire or before the admission agreement is signed, a notation will be made in the client or participant record as to why it was not signed.
 - Each individual should be observed and physically checked for life signs at least every 30 minutes during the first 12 hours following admission by a staff and/or a volunteer. The observation and physical checks should continue beyond the initial 12-hour period for as long as the withdrawal signs and symptoms warrant. Documentation of the information that supports a decrease in observation and

⁴ Presentation Materials — Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁵ Information published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁶ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

physical checks must be recorded in the client's record by a staff and/or a volunteer. The observation cannot be accomplished by use of another client.

- For individuals in substance abuse residential detoxification programs who are HIV/AIDS infected, a transmission assessment should be performed prior to discharge.
 - For individuals in substance abuse residential detoxification programs who are assessed as "ready" for additional HIV/AIDS information, transmission risk and infection risk education should be provided. Programs assessing readiness are encouraged to use Prochaska's Transtheoretical Model of Personal Change⁷, which identifies six stages of personal change, including precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska et al. maintains that individuals move through predictable stages of change as they endeavor to overcome problem behaviors.
- ***Intake and Assessment:*** Prior to accepting a client into a substance abuse residential detoxification program, the person responsible for admissions must interview the prospective client and his/her authorized representative, if any, to document the following:
 - ***Eligibility Determination:*** Persons eligible for substance abuse residential detoxification services must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance dependence and meet the following criteria⁸:
 - Withdrawal Potential — severe withdrawal risk;
 - Biomedical Conditions — requires medical monitoring;
 - Emotional/Behavioral Conditions — at least moderate severity needing 24-hour structured setting;
 - Treatment Acceptance/Resistance — resistance high despite negative consequences and needs intensive motivating strategies in 24-hour structure;
 - Relapse Potential — unable to control use and needs 24-hour structure; and
 - Recovery Environment — environment dangerous for recovery necessitating removal from the environment; logistical impediments to outpatient treatment.
 - ***Assessment:*** The assessment process should include utilization of the Addiction Severity Index. The client may not be in a physical, mental and emotional state to participate in the assessment using the ASI until well into his/her detoxification program.

The assessment process should include a broad variety of components that will yield an evaluation of the client that is as comprehensive and holistic as possible. The assessment should provide the information required to recommend the most appropriate course of treatment. Areas that should be investigated in the assessment include⁹:

⁷ Prochaska's Transtheoretical Model of Personal Change (Prochaska, Norcross & DiClemente, 1994).

⁸ American Society of Addiction Medicine Patient Placement Criteria.

⁹ Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

- the history of previous withdrawals, including a history of delirium tremens, seizures, or convulsions;
- archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments, treatment records, and detoxification episodes;
- patterns of alcohol and drug (AOD) use;
- impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;
- risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;
- available health and medical findings, including emergency medical needs;
- psychological test findings;
- educational and vocational background;
- suicide, health, or other crisis risk appraisal;
- client motivation and readiness for treatment;
- client attitudes and behavior during assessment; and
- client HIV risk behaviors and factors.

In addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor should coordinate with the client's medical care provider to ascertain information regarding¹⁰:

- medical history,
- results of a physical examination, and
- results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- *Client Education:* Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS¹¹.
- **Treatment Plan:** A treatment plan must be developed for all clients based upon the initial assessment. This treatment plan should serve as the framework for type and duration of services provided during the client's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.

¹⁰ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹¹ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

The client must sign an admission agreement authorizing treatment within seven days of admission and prior to discharge. A counselor must develop a treatment plan for each client with collaboration from the client if the client is able to participate.

Treatment plan requirements include¹²:

- an interim treatment plan, which identifies the client's immediate treatment needs, must be developed within 24-hours from the date of admission;
 - treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified;
 - the treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the detoxification goal, and must reflect the client's changing needs;
 - treatment plan goals and objectives must be broken down into manageable, measurable units;
 - each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client; and
 - the treatment plan must demonstrate how the resident or participant will be transitioned from detoxification to community support services.
- ***Referral Services:*** In addition to primary medical services and case management, the program must be linked to a continuum of HIV/AIDS care and services and must link and/or refer clients to these service options, including, but not limited to, mental health, medical care, and legal and financial services¹³. Referrals for services should be made at any point at which the needs of the client cannot be met by the program within its established range of services. In addition:
 - if during intake it is determined that the needs of the client cannot be met by the program within the program's range of services, then a referral must be made to an alternate provider or venue of services; and
 - if after admission observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral, or transfer to another type of program, the program staff must consult with the appropriate specialist(s), as necessary, to assist in determining if such can be met by the program within the program's range of services or if a referral and transfer is required.
 - ***Contagious/Infectious Disease Prevention and Intervention:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.

¹² Excerpted from Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

¹³ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

- **Support Services and Discharge Planning:** Support services that are to be provided or coordinated must include, but are not limited to:
 - provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living),
 - health-related services (e.g., medication management services),
 - transmission risk assessment and prevention counseling,
 - social services,
 - recreational activities,
 - meals,
 - housekeeping and laundry,
 - transportation, and/or
 - housing.

Discharge planning should include a written aftercare plan that includes specific substance abuse treatment recommendations utilizing different modalities and approaches. Clients should be offered the opportunity to participate in the aftercare planning process and should receive a copy of the plan, including active referrals to appropriate services. Clients should leave knowing they are welcome to contact the program at any time. Programs should maintain contact with clients post-discharge¹⁴.

- **Quality Management:** The program should implement an annual Quality Management (QM) Plan that addresses the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports. The program must comply with contractual requirements related to QM.
- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency¹⁵.

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an individual treatment plan. (Goal – 100%)
2. Establish baseline and perform ongoing monitoring of the percent of clients who have had at least one medical care consultation during the substance abuse treatment episode.

¹⁴ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁵ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with the services received through the program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the treatment plan. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING¹⁶

The Substance Abuse Residential Detoxification program must have the following staff:

- ***Administrative and Support Staff:***
 - A nurse practitioner or a physician's assistant manages the day-to-day program operations and must be on-site a minimum of four hours per day. If staff of the program does not include a nurse practitioner or physician's assistant, the medical director's time in the program is expanded.
 - A registered nurse should remain on-call, and nurse's aides (such as rehabilitation technicians or detoxification aides) should be on duty at all times. Appropriate support for the nurse's aides includes, at a minimum, a nurse and a back-up physician.
 - Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- ***Direct Care Staff:*** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - a counselor designated to perform admission, intake and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - a counselor responsible for oversight and provision of planned activities, including oversight of volunteers;
 - at least one staff member and/or volunteer with current first-aid training on-duty and awake at all times;
 - a medical staffing ratio of not less than one nurse for every 24 clients enrolled in the program; and
 - a staffing ratio of not less than one counselor for every 12 clients enrolled in the program¹⁷. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or

¹⁶ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

¹⁷ Mercer Government Human Services Consulting Best Practices Review.

experience in treating persons with an addiction and have specialized training in detoxification services. Clients will not be used to fulfill staffing requirements.

LENGTH OF STAY

Not to exceed 14 days; extensions can only be granted in special circumstances and with a physician's order.

SERVICES

Substance Abuse Adult Residential Detoxification services include¹⁸:

- Initial Screening,
- Client Assessment,
- Intake,
- Treatment plan,
- Provision of medication prescribed by a medical professional within his/her scope of practice to lessen the effects of withdrawal,
- Treatment Services:
 - crisis intervention;
 - individual counseling;
 - couples counseling;
 - family counseling; and
 - group counseling,
- Support Groups, and
- Treatment Linkages:
 - treatment advocate/educator;
 - medical provider;
 - case management; and
 - nutrition.

MEDI-CAL COVERAGE

This service is not a Drug Medi-Cal covered service; however, it is a Medi-Cal covered service.

¹⁸ County of Los Angeles contract, Additional Provisions, February 26, 2002.

**Department of Health Services
Office of AIDS Programs and Policy**

**Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County of Los Angeles Department of Health Services/Office of AIDS Programs and Policy. This description is intended to guide providers of services in the development and implementation of services to individuals living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Substance Abuse Residential Rehabilitation

LICENSURE CATEGORY

High Level Intensity Program
Medium Level Intensity Program
Low Level Intensity Program

DEFINITIONS AND DESCRIPTIONS

“Alcoholism or Drug Abuse Treatment Facility” or “Facility” means any premises, place, building, or group of buildings where 24-hour, residential, non-medical services are provided individuals who are recovering from problems related to alcohol and/or other drug abuse and who need alcohol and/or other drug abuse treatment or detoxification services¹.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam, and the Persian Gulf combined². In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS³. Intravenous drug use is second only to intercourse with an HIV-positive man as the most common method of infection⁴. Existing performance standards for the delivery of care typically target either HIV or substance use, but rarely addresses the integration of these two services. HIV-positive substance

¹ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

² AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

³ Presentation Materials — Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁴ Information published on County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

abusers have a wide spectrum of health care needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, services such as primary care, substance abuse treatment, mental health treatment, and support services should be integrated and easily accessible. Research has demonstrated that coordination of care, particularly for clients accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved health outcomes⁵.

PROGRAM REQUIREMENTS

The following are minimum requirements for substance abuse residential rehabilitation programs. Programs may exceed these requirements.

- **General Requirements:** The program must ensure its ability to meet the needs of the client by meeting the following general requirements:
 - Substance abuse residential rehabilitation programs must be licensed by the Department of Alcohol and Drug Programs as a Residential Alcoholism or Drug Abuse Treatment Facility.
 - Residential Alcoholism or Drug Abuse Treatment Facilities must operate in accordance with Chapter 5, Division 4, Title 9 of the California Code of Regulations.
 - For individuals in substance abuse residential rehabilitation programs who are HIV/AIDS infected, regular on-going transmission assessments should be performed.
 - For individuals in substance abuse residential rehabilitation programs who are assessed as “ready” for additional HIV/AIDS information, transmission risk and infection risk education should be provided. Programs assessing readiness are encouraged to use Prochaska's Transtheoretical Model of Personal Change⁶, which identifies six stages of personal change, including precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska et al. maintains that individuals move through predictable stages of change as they endeavor to overcome problem behaviors.
- **Intake and Assessment:** Prior to accepting a client into a substance abuse residential rehabilitation program, the person responsible for admissions must interview the prospective client and his/her authorized representative, if any, to document the following:

⁵ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

⁶ Prochaska's Transtheoretical Model of Personal Change (Prochaska, Norcross & DiClemente, 1994).

For high level intensity programs:

- *Eligibility Determination:* Persons eligible for substance abuse residential services must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance dependence and exhibit the following⁷:
 - Withdrawal Potential — minimal risk of severe withdrawal,
 - Biomedical Conditions — none or stable; receiving concurrent medical monitoring for medical conditions,
 - Emotional/Behavioral Conditions — repeated inability to control impulses; requires structure to shape behavior,
 - Treatment Acceptance/Resistance — marked difficulty with or opposition to treatment with dangerous consequences if not engaged in treatment,
 - Relapse Potential — high likelihood of relapse without close monitoring and support, and
 - Recovery Environment — environment is dangerous for recovery; client lacks skills to cope outside of a highly structure 24-hour setting.
- *Assessment:* For all levels of residential treatment, the assessment process should include utilization of the Addiction Severity Index as a functional assessment and the American Society of Addiction Medicine Patient Placement Criteria as a level of care assessment.

The high level intensity residential rehabilitation program must:

- use the standardized screening tool, the Addictions Severity Index;
- complete a comprehensive assessment that includes⁸:
 - archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records,
 - patterns of alcohol and drug (AOD) use,
 - impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept,
 - risk factors for continued AOD abuse, such as family history of AOD abuse and social problems,
 - available health and medical findings, including emergency medical needs,
 - psychological test findings,
 - educational and vocational background,
 - suicide, health, or other crisis risk appraisal,
 - client motivation and readiness for treatment, and
 - client attitudes and behavior during assessment;
- in addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client,

⁷ American Society of Addiction Medicine Patient Placement Criteria.

⁸ Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

the assessor should coordinate with the client's medical care provider to ascertain information regarding⁹:

- medical history,
- results of a physical examination, and
- results of laboratory tests and follow up required; and
- client HIV risk behaviors and factors.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- *Client Education:* Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS¹⁰.

For medium level intensity programs:

- *Eligibility Determination:* Persons eligible for substance abuse residential services must have a DSM-IV diagnosis of substance dependence and exhibit the following¹¹:
 - Withdrawal Potential — no severe withdrawal risk,
 - Biomedical Conditions — none or stable,
 - Emotional/Behavioral Conditions — mild to moderate severity; needs structure to allow focus on recovery,
 - Treatment Acceptance/Resistance — little awareness; client needs interventions to engage and stay in treatment,
 - Relapse Potential — likelihood of relapse without close monitoring and support, and
 - Recovery Environment — environment is dangerous for recovery; client needs 24-hour structure to learn to cope.
- *Assessment:* The medium level intensity residential rehabilitation program must:
 - use the standardized screening tool, the Addictions Severity Index;
 - complete a comprehensive assessment that includes¹²:
 - archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records,
 - patterns of AOD use,

⁹ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹⁰ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹¹ American Society of Addiction Medicine Patient Placement Criteria.

¹² Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

- impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept,
- risk factors for continued AOD abuse, such as family history of AOD abuse and social problems,
- available health and medical findings, including emergency medical needs,
- psychological test findings,
- educational and vocational background,
- suicide, health, or other crisis risk appraisal,
- client motivation and readiness for treatment, and
- client attitudes and behavior during assessment; and
- in addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor should coordinate with the client's medical care provider to ascertain information regarding¹³:
 - medical history,
 - results of a physical examination, and
 - results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- *Client Education:* Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS¹⁴.

For low level intensity programs:

- *Eligibility Determination:* Persons eligible for substance abuse residential services must have a DSM-IV diagnosis of substance dependence and exhibit the following¹⁵:
 - Withdrawal Potential — no withdrawal risk,
 - Biomedical Conditions — none or stable,
 - Emotional/Behavioral Conditions — none or minimal; not distracting to recovery,
 - Treatment Acceptance/Resistance — open to recovery, but needs structured environment to maintain therapeutic gains,

¹³ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹⁴ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁵ American Society of Addiction Medicine Patient Placement Criteria.

- Relapse Potential — likelihood of relapse without close monitoring and support, and
 - Recovery Environment — environment is dangerous but recovery achievable if structure is available.
- *Assessment:* The low level intensity residential rehabilitation program must:
- use the standardized screening tool, the Addictions Severity Index;
 - complete a comprehensive assessment that includes¹⁶:
 - archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records,
 - patterns of AOD use,
 - impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept,
 - risk factors for continued AOD abuse, such as family history of AOD abuse and social problems,
 - available health and medical findings, including emergency medical needs,
 - psychological test findings,
 - educational and vocational background,
 - suicide, health, or other crisis risk appraisal,
 - client motivation and readiness for treatment, and
 - client attitudes and behavior during assessment; and
 - in addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor should coordinate with the client's medical care provider to ascertain information regarding¹⁷:
 - medical history,
 - results of a physical examination, and
 - results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- *Client Education:* Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS¹⁸.

¹⁶ Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

¹⁷ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹⁸ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

- ***Treatment Plan:*** A treatment plan must be developed for all clients based upon the initial assessment. This treatment plan should serve as the framework for type and duration of services provided during the client's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.

For high level intensity programs¹⁹:

- The client must sign an admission agreement authorizing treatment within three days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include:
- An interim treatment plan which identifies the client's immediate treatment needs must be developed within three days from the date of admission.
- Within 10 days from the date of admission, the counselor must develop a comprehensive treatment plan with long-and short-term goals for the continuing treatment needs of each client.
- Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified.
- The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs.
- Treatment plan goals and objectives must be broken down into manageable, measurable units.
- The treatment plan must be reviewed and re-evaluated 28 days after development and every 30 days thereafter or more often, if needed, as the client completes each phase of treatment.
- Each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.

For medium level intensity programs²⁰:

- The client must sign an admission agreement authorizing treatment within three days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include:
- An interim treatment plan which identifies the client's immediate treatment needs must be developed within three days from the date of admission.
- Within 14 days from the date of admission, the counselor must develop a comprehensive treatment plan with long- and short-term goals for the continuing treatment needs of each client.
- Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified.

¹⁹ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

²⁰ Ibid.

- The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs.
- Treatment plan goals and objectives must be broken down into manageable, measurable units.
- The treatment plan must be reviewed and re-evaluated 28 days after development and every 60 days thereafter or more often, if needed, as the client completes each phase of treatment.
- Each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.

For low level intensity programs²¹:

- The client must sign an admission agreement authorizing treatment within three days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. treatment plan requirements include²²:
 - An interim treatment plan which identifies the client's immediate treatment needs must be developed within three days from the date of admission.
 - Within 20 days from the date of admission, the counselor must develop a comprehensive treatment plan with long- and short-term goals for the continuing treatment needs of each client.
 - Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified.
 - The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs.
 - Treatment plan goals and objectives must be broken down into manageable, measurable units.
 - The treatment plan must be reviewed and re-evaluated 28 days after development and every 90 days thereafter or more often, if needed, as the client completes each phase of treatment.
 - Each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.
- **Referral Services:** In addition to primary medical services and case management, all intensity levels of residential rehabilitation programs must be linked to a continuum of HIV/AIDS care and services and must link and/or refer clients to these service options, including, but not limited to, mental health, medical care, and legal and financial services²³. Referrals for services should be made at any point at which the needs of the client cannot be met by the program within its established range of services. In addition:

²¹ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

²² Ibid.

²³ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

- if during intake it is determined that the needs of the client cannot be met by the program within the program's range of services, then a referral must be made to an alternate provider or venue of services; and
 - If after admission observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral or transfer to another type of program, the program staff must consult with the appropriate specialist(s), as necessary, to assist in determining if such can be met by the program within the program's range of services or if a referral and transfer is required.
- ***Contagious/Infectious Disease Prevention and Intervention:*** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.
 - ***Support Services and Discharge Planning:*** Support services that are to be provided or coordinated must include, but are not limited to:
 - provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living),
 - health-related services (e.g., medication management services),
 - transmission risk assessment and prevention counseling,
 - social services,
 - recreational activities,
 - meals,
 - housekeeping and laundry,
 - transportation, and/or
 - housing.

Discharge planning should include a written aftercare plan that includes specific substance abuse treatment recommendations utilizing different modalities and approaches. Clients should be offered the opportunity to participate in the aftercare planning process and should receive a copy of the plan including active referrals to appropriate services. Clients should leave knowing they are welcome to contact the program at any time. Programs should maintain contact with clients post-discharge²⁴.

- ***Quality Management:*** The program should implement an annual Quality Management (QM) Plan that addresses the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality

²⁴ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

Assessment and Management Reports. The program must comply with contractual requirements related to QM.

- **Cultural Competence:** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency²⁵.

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an individual treatment plan. (Goal – 100%)
2. Establish baseline and perform ongoing monitoring of the percent of clients who have had at least one medical care consultation during the substance abuse treatment episode.
3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with the services received through the program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the treatment plan. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING

The Substance Abuse Residential Rehabilitation program must have the following staff:

For high level intensity programs:

- **Administrative and Support Staff:**
 - the program administrator or designee must be on-site during the normal work day;
 - a registered nurse should remain on-call 24 hours a day;
 - in programs where there are six beds or fewer, a minimum of one on-duty, awake staff is required;
 - in programs where there are seven to 20 beds, a minimum of two on-duty, awake staff is required;

²⁵ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

- in programs where there are more than 20 beds, a minimum of one on-duty, awake staff is required for each additional 16 beds or portion thereof; and
 - support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- **Direct Care Staff:** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - a counselor designated to perform admission, intake, and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - a counselor responsible for oversight and provision of planned activities, including oversight of volunteers; and
 - a staffing ratio of not less than one counselor for every 16 clients enrolled in the program²⁶. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction and have specialized training in detoxification services. Clients will not be used to fulfill staffing requirements.

For medium level intensity programs:

- **Administrative and Support Staff:**
 - the program administrator or designee must be on-site or able to return telephone calls within one hour and able to appear in person within two hours;
 - the medical director should be on-call during regular business hours;
 - the program must ensure that whenever clients are present, at least one on-duty staff or resident manager is present;
 - in programs where there are less than six beds, a minimum of one on-duty staff or resident manager is required during service provision hours;
 - in programs where there are seven to 40 beds, a minimum of two on-duty staff or resident managers is required during service provision hours;
 - in programs where there are more than 40 beds, a minimum of one on-duty staff or resident manager is required for each additional 40 beds or portion thereof during service provision hours; and
 - support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- **Direct Care Staff:** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - a counselor designated to perform admission, intake, and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - a counselor responsible for oversight and provision of planned activities, including oversight of volunteers; and

²⁶ Mercer Government Human Services Consulting Best Practices Review.

- a staffing ratio of not less than one counselor for every 24 clients enrolled in the program²⁷. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction and have specialized training in detoxification services. Clients will not be used to fulfill staffing requirements.

For low level intensity programs:

- ***Administrative and Support Staff:***
 - the program administrator or designee must be on-site or able to return telephone calls within one and one-half hours and able to appear in person within three hours;
 - the program must ensure that whenever clients are present, at least one on-duty staff is present;
 - in facilities where there are less than six beds, a minimum of one on-duty staff is required during service provision hours;
 - in facilities where there are seven to 40 beds, a minimum of two on-duty staff is required during service provision hours;
 - in facilities where there are more than 40 beds, a minimum of one on-duty staff is required for each additional 40 beds or portion thereof during service provision hours; and
 - support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- ***Direct Care Staff:*** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - counselor designated to perform admission, intake, and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - counselor responsible for oversight and provision of planned activities, including oversight of volunteers; and
 - a staffing ratio of not less than one counselor for every 40 clients enrolled in the program²⁸. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction and have specialized training in detoxification services. Clients will not be used to fulfill staffing requirements.

LENGTH OF STAY

Based on the assessment of the client's need using the American Society of Addiction Medicine Patient Placement Criteria, a client may move from one intensity level of services to another.

²⁷ Mercer Government Human Services Consulting Best Practices Review.

²⁸ Mercer Government Human Services Consulting Best Practices Review.

High Level Intensity Program — not to exceed 8 weeks, although an extension can be made as long as the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine Patient placement criteria. At any point during treatment, the client may move to a lower level of residential treatment, to outpatient treatment services or to aftercare services depending on his or her individual need.

Medium Level Intensity Program — not to exceed 12 weeks, although an extension can be made as long as the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine Patient placement criteria in accordance with the American Society of Addiction Medicine Patient placement criteria. At any point during treatment, the client may move to a higher or lower level of residential treatment, to outpatient treatment services or to aftercare services depending on his or her individual need.

Low Level Intensity Program — not to exceed 16 weeks, although an extension can be made as long as the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine Patient placement criteria. At any point during treatment, the client may move to a higher or lower level of residential treatment, to outpatient treatment services or to aftercare services depending on his or her individual need.

SERVICES

General Services — Regardless of Intensity of Program

- The program should actively engage clients in treatment with an emphasis on:
 - interventions, activities, or service elements uniquely designed to alleviate or preclude alcohol and/or other drug problems in the individual, their family, and/or the community;
 - the goals of physical health and well-being, practical life skills, including the ability to be self-supporting, improved personal functioning, and effective coping with life problems;
 - social functioning, including improved relationships with family, socially acceptable ethics, and enhanced communication and interpersonal relationship skills;
 - improving the individual's self-image, esteem, confidence, insight, understanding, and awareness; and
 - additional life skills such as communication, finance management, hygiene, training in leisure, homemaking and parenting skills, stress, relaxation, anger management, physical fitness, and field trips.
- The program must ensure that, to the maximum extent possible, the program staff provides information regarding community resources and their utilization. The program must maintain and make available to residents a current list of resources within the community that offer services that are not provided within the program. At a minimum, the list of resources includes medical, dental, mental health, public health, and social services, and where to apply for the determination of eligibility for State, federal, or county entitlement programs.
- Referrals should be made to these outside resources, as appropriate.

- Each program, regardless intensity level at which it is licensed, must provide services including counseling sessions to clients, as reflected in the client's treatment/recovery plan.

In addition to general service requirements, specific service requirements include²⁹:

- For high level intensity programs:
 - a minimum of 80 hours of services per week are provided,
 - a minimum five group sessions per week are provided,
 - a minimum one individual session per week is provided, and
 - a minimum three educational sessions per week are provided.
- For medium level intensity programs:
 - a minimum of 40 hours of services per week are provided,
 - a minimum three group sessions per week are provided, and
 - a minimum one educational session per week is provided.
- For low level intensity programs:
 - a minimum of 20 hours of services per week are provided, and
 - a minimum one group session per week is provided.

MEDI-CAL COVERAGE

This service is not a Drug Medi-Cal covered service, except for perinatal women or women in the postpartum period, and/or to Early and Periodic Screening Diagnosis and Treatment (EPSDT)-eligible beneficiaries.

²⁹ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft.

**Department of Health Services
Office of AIDS Programs and Policy
Residential and Substance Abuse Services
Special Rate Study**

SERVICE DESCRIPTION

The following represents a service description adopted by the County of Los Angeles Department of Health Services/Office of AIDS Programs and Policy. This description is intended to guide providers of services in the development and implementation of services to individuals living with HIV/AIDS. California statutes, regulations, and rules governing licensing and service provision take precedence.

SERVICE

Substance Abuse Transitional Housing

LICENSURE CATEGORY

Non-licensed

DEFINITIONS AND DESCRIPTIONS

“Transitional Housing” means housing with supportive services for up to four months that are exclusively designated and targeted for recently homeless persons¹.

“Transitional Housing” provides interim housing for persons who are in various stages of recovery from substance abuse. The purpose of transitional housing is to facilitate continued recovery from substance abuse and movement toward more traditional and permanent housing².

“HIV/AIDS transitional housing” is interim housing for homeless persons with HIV disease or AIDS. The purpose of these housing services is to facilitate movement towards more traditional and permanent housing through assessment of the individual’s needs, counseling, and case management³.

¹ HIV/AIDS and Substance Use Standards of Care, County of Los Angeles Commission on HIV Health Services, 1999.

² Ibid.

³ Ibid.

“Homeless” persons are defined as individuals with HIV disease or AIDS who lack a fixed, regular, and adequate residence or reside in: 1) a shelter designed to provide temporary, emergency living accommodations; 2) an institution that provides a temporary residence for individuals intended to be institutionalized; or 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings⁴.

IMPACT OF HIV/AIDS

More Americans have died of AIDS than in World War I, World War II, Korea, Vietnam, and the Persian Gulf combined⁵. In the County of Los Angeles, it is estimated that more than 53,000 people are living with HIV/AIDS⁶. Intravenous drug use is second only to intercourse with an HIV-positive man as the most common method of infection⁷. Existing performance standards for the delivery of care typically target either HIV or substance use, but rarely addresses the integration of these two services. HIV-positive substance abusers have a wide spectrum of health care needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, services such as primary care, substance abuse treatment, mental health treatment, and support services should be integrated and easily accessible. Research has demonstrated that coordination of care, particularly for clients accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved health outcomes⁸.

PROGRAM REQUIREMENTS

The following are minimum requirements for substance abuse transitional housing. Programs may exceed these requirements.

- **General requirements:** For licensed programs operating an adult residential facility, a community care facility, a transitional housing facility, or a congregate living facility which offer substance abuse transitional housing, general program requirements are established in standards describing the licensed service. For substance abuse transitional housing services which are not licensed, requirements include⁹:
 - Each program will have and maintain on file a current, written, definitive plan of operation including, admission policies and procedures regarding acceptance of clients, a copy of the admission agreement, staffing plan, qualifications and

⁴ County of Los Angeles contract, Substance Abuse Transitional Housing Service Agreement, February 26, 2002.

⁵ AIDS Facts, Published by County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁶ Presentation Materials — Community Advisory Group Orientation, County of Los Angeles, Department of Health, Office of AIDS Programs and Policy, May 27, 2003.

⁷ Information published on County of Los Angeles, Department of Health, Office of AIDS Programs and Policy.

⁸ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

⁹ Excerpted from Chapters 2 through 7 and Chapter 9, Division 6, Title 22 California Code of Regulations.

- duties, and a plan for in-service education of staff, if required by regulations governing the specific facility category.
- The program will assist with transportation arrangements for clients who do not have independent arrangements.
 - The program will provide ample opportunities for family participation in activities in the facility.
 - If the program intends to admit and/or specialize in care for one or more clients who have a propensity for behaviors that result in harm to self or others, the plan of operation will include a description of precautions that will be taken to protect that client and all other clients.
- The program must ensure its ability to meet the needs of the client by meeting the following general requirements:
 - For individuals in substance abuse transitional housing programs who are HIV/AIDS infected, regular on-going transmission assessments should be performed.
 - For individuals in substance abuse transitional housing programs who are assessed as “ready” for additional HIV/AIDS information, transmission risk and infection risk education should be provided. Programs assessing readiness are encouraged to use Prochaska's Transtheoretical Model of Personal Change¹⁰, which identifies six stages of personal change, including precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska et al. maintains that individuals move through predictable stages of change as they endeavor to overcome problem behaviors.
 - ***Intake and Assessment:*** Prior to accepting a client into a substance abuse transitional housing program, the person responsible for admissions must interview the prospective client and his/her authorized representative, if any, to document the following:
 - ***Eligibility Determination:*** Persons eligible for substance abuse transitional housing must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance dependence or have recently completed (within six weeks) a substance abuse treatment program. The person must be in need of interim housing services.
 - ***Assessment:*** The assessment process should include utilization of the Addiction Severity Index.

The assessment process should include a broad variety of components that will yield an evaluation of the client that is as comprehensive and holistic as possible. The assessment should provide the information required to recommend the most appropriate course of treatment. Areas that should be investigated in the assessment include¹¹:

¹⁰ Prochaska's Transtheoretical Model of Personal Change (Prochaska, Norcross & DiClemente, 1994).

¹¹ Screening and Assessment for Alcohol and Other Drug Abuse Among Adults, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1994.

- archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records;
- patterns of alcohol and drug (AOD) use;
- impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;
- risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;
- available health and medical findings, including emergency medical needs;
- psychological test findings;
- educational and vocational background;
- suicide, health, or other crisis risk appraisal;
- client motivation and readiness for treatment;
- client attitudes and behavior during assessment; and
- client HIV risk behaviors and factors.

In addition, the assessment should include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor should coordinate with the client's medical care provider to ascertain information regarding¹²:

- medical history,
- results of a physical examination, and
- results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider should be made and a priority treatment plan item should be developed for the client to seek and comply with medical care.

- ***Client Education:*** Client and family education is a continuous process that includes prevention, risk reduction practices, harm reduction, licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS¹³.
- ***Treatment Plan:*** A treatment plan must be developed for all clients based upon the initial assessment. This treatment plan should serve as the framework for type and duration of services provided during the client's stay in the program and should include the plan review and reevaluation schedule. The program staff should regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan should also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services and case management services.

¹² Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

¹³ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

The client must sign an admission agreement authorizing treatment within three days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include¹⁴:

- An interim treatment plan which identifies the client's immediate treatment needs must be developed within three days from the date of admission.
 - Within 14 days from the date of admission, the counselor must develop a comprehensive treatment plan with long and short term goals for the continuing treatment needs of each client.
 - Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified.
 - The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs.
 - Treatment plan goals and objectives must be broken down into manageable, measurable units.
 - The treatment plan must be reviewed and re-evaluated 28 days after development and every 90 days thereafter or more often, if needed, as the client completes each phase of treatment.
 - Each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.
- **Referral Services:** In addition to primary medical services and case management, the program must be linked to a continuum of HIV/AIDS care and services and must link and/or refer clients to these service options, including, but not limited to, mental health, medical care, and legal and financial services¹⁵. Referrals for services should be made at any point at which the needs of the client cannot be met by the program within its established range of services. In addition:
 - if during intake it is determined that the needs of the client cannot be met by the program within the program's range of services, then a referral must be made to an alternate provider or venue of services; and
 - if after admission observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral, or transfer to another type of program, the program staff must consult with the appropriate specialist(s), as necessary, to assist in determining if such can be met by the program within the program's range of services or if a referral and transfer is required.
 - **Contagious/Infectious Disease Prevention and Intervention:** The client must meet the admission requirements of the County of Los Angeles Department of Health Services Tuberculosis Control Program. Clients should be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a

¹⁴ Excerpted from Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft; Low Intensity Residential Services.

¹⁵ Ryan White Title II Standards of Services, Housing Services, Oregon Department of Human Services, Health Services, June 2002, p. 13.

contagious or infectious disease, the client should be isolated and a physician should be consulted to determine suitability of the client's retention in the program.

- ***Support Services and Discharge Planning:*** Support services that are to be provided or coordinated must include, but are not limited to:
 - provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living),
 - health-related services (e.g., medication management services),
 - transmission risk assessment and prevention counseling,
 - social services,
 - recreational activities,
 - meals,
 - housekeeping and laundry,
 - transportation, and/or
 - housing.

Discharge planning should include a written aftercare plan that includes specific substance abuse treatment recommendations utilizing different modalities and approaches. Clients should be offered the opportunity to participate in the aftercare planning process and should receive a copy of the plan including active referrals to appropriate services. Clients should leave knowing they are welcome to contact the program at any time. Programs should maintain contact with clients post-discharge¹⁶.

- ***Quality Management:*** The program should implement an annual Quality Management (QM) Plan that addresses the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports.
- ***Cultural Competence:*** Program staff should display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency¹⁷.

INDICATORS

1. Establish baseline and perform on-going monitoring of the percent of clients with an individual treatment plan. (Goal – 100%)
2. Establish baseline and perform ongoing monitoring of the percent of clients who have had at least one medical care consultation during the substance abuse treatment episode.

¹⁶ Guiding Principles for Programs Serving HIV Positive Substance Users, Health & Disability Working Group, Boston University School of Public Health, June 2003.

¹⁷ Treatment for HIV-Infected Alcohol and Other Drug Abusers, Treatment Improvement Protocol, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1995.

3. Establish baseline and perform on-going monitoring of the percent of clients that report general satisfaction with the services received through the program. (Goal – 90%)
4. Establish baseline and perform on-going monitoring of the percent of clients referred to and linked with community resources as specified in the treatment plan. (Goal – 100%)
5. Establish baseline and perform on-going monitoring of the percent of clients that report increased knowledge of harm-reducing and risk-reducing techniques, including recognizing triggers for high-risk behaviors related to HIV. (Goal – 90%)

REQUIRED STAFFING¹⁸

The Substance Abuse Transitional Housing program must have the following staff:

- ***Administrative and Support Staff:***
 - the facility administrator or designee must be on-site or able to return telephone calls within one and one-half hours and able to appear in person within three hours; and
 - support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.
- ***Direct Care Staff:*** The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include:
 - a counselor designated to perform admission, intake and assessment functions, including ongoing evaluation of the clients' treatment and care needs;
 - a counselor responsible for oversight and provision of planned activities, including oversight of volunteers;
 - the program must ensure that whenever clients are present, at least one on-duty staff is present;
 - in programs where there are less than six beds, a minimum of one on-duty staff is required during service provision hours;
 - in programs where there are seven to 40 beds, a minimum of two on-duty staff are required during service provision hours; and
 - in facilities where there are more than 40 beds, a minimum of one on-duty staff is required for each additional 40 beds or portion thereof during service provision hours.

¹⁸ Chapter 5, Division 4, Title 9, of the California Code of Regulations, Draft, Low Level Intensity Residential Substance Abuse Services.

LENGTH OF STAY¹⁹

The length of stay varies, but is limited to four months. Substance abuse transitional housing is offered until the client transitions to a more independent living environment. Any extensions beyond the four month length of stay require prior approval from OAPP.

SERVICES²⁰

- Referral of clients for medical care, case management, substance abuse treatment, and any other services that may be beneficial to the clients.
- Assistance with locating and becoming eligible for permanent housing.

MEDI-CAL COVERAGE

This is not a Drug Medi-Cal covered service.

¹⁹ County of Los Angeles contract, Substance Abuse Transitional Housing Service Agreement, February 26, 2002.

²⁰ A Summary Report on California's Programs to Address Homelessness. Prepared for Governor Gray Davis, March, 2002, page 33.